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MANITOBA MEDICAL REVIEW

VOL. 26

1946

SYMPTOMS. Local invasion of soft tissues, especially invasion of the parotid gland, with swelling and tenderness. A single abscess may develop, or multiple abscesses may form. The infection is usually caused by a streptococcus, also indicated by the presence of a high infection titer in blood and sputum.

DIAGNOSIS. A single abscess should be removed and a culture done. If there is no abscess, a biopsy should be made showing evidence of abscess. To rule out other diseases, studies of the gland of the lung, such as the parotid gland, should be made. Early removal of the gland is advised. Late removal may cause complications.

PROGNOSIS. The local disease is usually self-limiting.

invasion of the soft tissues, especially invasion of the parotid gland. If removed, the disease is usually self-limiting. The disease is usually caused by a streptococcus, also indicated by the presence of a high infection titer in blood and sputum.

DIAGNOSIS. A single abscess should be removed and a culture done. If there is no abscess, a biopsy should be made showing evidence of abscess.

To rule out other diseases, studies of the gland of the lung, such as the parotid gland, should be made.



Published
in partnership
with the
University of
Manitoba
Press, Ltd.
Winnipeg, Manitoba

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VOL. 38

1955

"From the standpoint of minimal systemic toxicity and maximal local antibacterial potency, sulfathiazole in chewing gum seems to be the preferable local chemotherapy for infections of oral and pharyngeal mucosa which are susceptible to sulfonamide compounds."

—Fox, N., Kesel, R. G., Neary, E. R. and Herbine, R. H.:
Effect of Sulfathiazole in Chewing Gum in Certain
Oropharyngeal Infections, Arch. of Otolaryngology,
41:278-283 (April) 1945.

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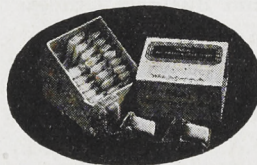
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Manitoba Medical Review

Published on the First of Each Month by the Manitoba Medical Association
Editorial and Business Offices: 510 Medical Arts Building, Winnipeg

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Uterine Bleeding

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Abnormal uterine bleeding is the most important of all the symptoms which indicate gynaecological disease. It is true, nevertheless, that whereas bleeding from the lung, the stomach, the intestine or the urinary tract is always viewed with alarm by the patient, bleeding from the uterus, unless it is severe enough to cause a constitutional reaction, is frequently ignored. Women who habitually accept the inconvenience of the monthly physiological bleeding of menstruation, are often slow to interpret irregularities or excesses as a source of concern. The absence of bleeding more often causes consternation than does that excess which may foretell the gravest disease.

Abnormal uterine bleeding may be associated with pregnancy, but in this presentation we shall consider it apart from that state. Therefore it will be looked upon as a sign of organic disease or as a disturbance of those endocrine glands which ordinarily control the function of menstruation.

The modern genius of advertising has surpassed itself in the flood of literature emanating from the pharmaceutical houses which manufacture endocrine preparations. If from no other source the education of the medical profession has been complete—here it is surfeited with books, pamphlets and papers. It is unfortunate that a much more positive relationship is presented between disturbances of function and specific therapy than experience warrants. On the other hand, however, much valuable information has been presented so that it is common knowledge that the anterior lobe of the pituitary gland secretes two gonadotropic hormones which in proper balance control the function of the ovary. One of these stimulates the development of the Graafian follicle, and the second prompts the formation and maintenance of the corpus luteum. If ovarian function is normal, the follicle secretes the proper amount of estrin to cause a normal proliferation of the endometrium, and this is followed in due time by a proper amount of progestin from the corpus luteum to supplement the secretion of estrin and to produce secretory or pregravid changes in the proliferated endometrium. The further life of the corpus luteum depends on the occurrence of pregnancy. If this does not take place the corpus luteum rapidly regresses and menstruation occurs.

It is generally supposed that bleeding occurs as a consequence of a fall in the estrin-progestin blood level. Markee has actually observed the vascular changes which are responsible for the bleeding of menstruation. He implanted endometrial tissue in the eye of the monkey and saw that the spiral arteries of the endometrium underwent marked constriction. This caused an ischaemia, and scattered areas of necrosis developed. Finally bleeding took place through the walls of the blood vessels. The recognition of this vascular phenomenon has altered our ideas with regard to the importance of the other changes in the endometrium so far as they affect the actual onset of bleeding.

It has been inherent to our conception of normal uterine function that ovulation should dominate menstruation. The idea that cyclic bleeding could occur in the absence of ovulation was at first very hard to accept. Now, however, it is known that this happens not infrequently at puberty and at the climacteric, and it is also true that some women have anovulatory periods during the years of sexual maturity.

When ovulation does not occur, the follicular hormone estrin is in entire control of the endometrium. As a result, the endometrium remains in the proliferative phase and does not progress to the pregravid or secretory phase. It becomes markedly thickened and under the microscope it is seen that the glands appear to be numerous with great variation in their size and shape. The stroma is compact and avascular, and the stromal cells are small with scant cytoplasm. This has been called the "Swiss Cheese" appearance, and the condition of the endometrium is diagnosed as glandular hyperplasia. Clinically this state of hyper-estrinism is usually manifested by irregular and profuse haemorrhages and, not infrequently, periods of amenorrhoea are interspersed between the spells of bleeding. Sometimes, however, the bleeding is more regular and takes the form of an excessive flow or the occurrence of too frequent periods. Such a development with the endometrium showing glandular hyperplasia constitutes a clear-cut pathological and clinical entity and to this is given the name Functional Uterine Bleeding.

Further study has shown that glandular hyperplasia is only present in a third to a half of the cases. At other times the endometrium may show

atrophy, normal proliferation or even a secretory pattern. This once more implies that the role of the endometrium may be purely passive and also that functional bleeding may occur when a corpus luteum is formed. Pure theory then suggests an immature or imperfect ovarian cycle with an imbalance between estrin and progesterin.

The diagnosis of functional uterine haemorrhage is made by a process of exclusion. Thorough general examination must rule out constitutional diseases. Careful pelvic examination must eliminate the possibility of polypi, fibroids, inflammatory disease, endometriosis and especially malignancy. In the establishment of a proper diagnosis curettage is the "sine qua non." By no other means can a proper opinion be formulated. From the first we must realize that bleeding is a symptom and not a disease, nature's danger signal, which must not be taken down until we know the reason why. Bleeding coming from the interior of the uterus cannot be explained until the condition of the entire lining of the uterus is studied. The most obvious pathology may blind us to the true cause of this symptom. A polypus may mask endocervical cancer or a fibroid conceal cancer of the body of the uterus. Let us not forget that diagnostic "genius is infinite painstaking."

Curettage must be thorough and, to be of the greatest value, should be performed before the expected bleeding or shortly after it has begun. If curettage is delayed until bleeding has been in progress for some days, most of the endometrium will have been cast off and the typical features cannot be appreciated. It is obvious that the pathologist should be given a full history; otherwise the report on the curettings may not answer the clinical problem.

Functional uterine bleeding may occur at puberty and continue into adolescence. As a rule the onset of bleeding is delayed for two or three years beyond the normal age. Usually the only treatment required is along general lines—iron, rest at the flow and ergot to control any excess. Often a blood examination will be reassuring to the physician, in spite of an alarming story from an anxious mother. Usually in the process of time endocrine function becomes established and normal menstruation follows. Some of these young patients may show features of hypothyroidism, and then thyroid therapy is of considerable value. Naturally curettage is seldom performed except in those rare cases when bleeding is dangerously profuse. Then it is not only diagnostic but curative, and with uterine packing and transfusion may be life-saving. My personal experience in recent years has been limited to two such cases of alarming severity. In treating these young patients I was influenced by the

opinion of Novak, and I supplemented curettage by giving Testosterone Propionate 25 mgm., repeated once. In both cases haemorrhage ceased and in a month in one case, and in six weeks in the other, an apparently normal period came on and was followed subsequently by normal menstruation.

Functional bleeding is not a common occurrence during the active period of sexual life. Careful examination will usually discover some other cause for abnormal bleeding. The diagnosis, however, is not always easy. Submucous and intramural fibroids are often hard to recognize. Sometimes bleeding occurs as the result of subinvolution of the uterus after pregnancy, especially if the uterus is retroverted. Pelvic inflammation may leave insignificant stigmata and yet alter the normal menstrual flow, and the same may be said of pelvic endometriosis. At all times it is of paramount importance to rule out the possibility of cancer of the cervix or of the body of the uterus.

When functional bleeding does occur at this age, it is very important to maintain unimpaired the reproductive capacity and the ovarian function. Therefore it is here that endocrine therapy should have its greatest field of usefulness. Unfortunately there is no unanimity of opinion with regard to the particular hormone which will prove most effective in controlling this excessive bleeding. Opinions are so conflicting that it is evident that such therapy remains purely empirical.

The advent of a hormone obtained from human pregnancy urine which was known to cause luteinization in the experimental animal, was hailed with enthusiasm. This chorionic gonadotropin theoretically, at least, should control functional bleeding. Experience now shows that it does so in a number of cases, but by what means we do not know. In the human it has little or no effect on the corpus luteum.

More recently there have been many reports in the literature on the use of progesterin or progesterone. This is simply substitutive therapy, and therefore falls short of affecting the underlying endocrine fault. However it is haemostatic, and the cessation of bleeding is followed in a few days by progesterin withdrawal bleeding. If it is given cyclicly for a week before the expected bleeding, it is often followed by the re-establishment of regular menstruation.

Novak advocates the use of androgenic hormone in the treatment of functional haemorrhage. Others criticize this practice because of the danger of masculinization. It is rather likely that the effect of this hormone is inhibitory on the anterior pituitary secretion, and thus indirectly affects the secretion of estrin. It also is an effective haemostat, and those who advocate its use follow

the original control of bleeding by cyclic treatment to re-establish normal menstruation.

Estrogen has been used by some to control functional haemorrhage, and so in practicing endocrine homoeopathy the wheel has turned full cycle. Hamblen advocates it in combination with progestin. Karnaky, on the other hand, uses huge doses which undoubtedly stop the bleeding, but this practice can hardly be accepted without considerable doubt as to its non-injurious effect. It is altogether likely that the high estrin level obtained has a depressing effect on anterior pituitary secretion and temporarily stops all ovarian activity.

So when we look at this endocrine empiricism, let us not forget that curettage alone will probably control fifty percent of these cases. Thyroid therapy, when permissible, will benefit many more. The crux of the question is whether or not ovulation will be re-established and the control of ovulation is unknown at present. The human endocrine chain is far more complicated and embracing than we can appreciate as yet, and in the absence of an accurate titre, our appreciation of the nature and amount of the endocrine fault has no scientific basis.

Most cases of functional bleeding occur in the menopausal years. At this age the desire to preserve ovarian function no longer hampers the efforts to control haemorrhage. Therefore the means employed may be more radical. Irradiation would seem to be the treatment of choice in women over forty-five years of age when one can be reasonably certain that no complication exists. Again let it be emphasized that curettage must be performed to safeguard the patient against having unrecognized cancer. Treatment by X-ray or radium means a short stay in hospital with little discomfort to the patient. At the menopause a full sterilization dose is given. But when irradiation treatment is used in younger patients a much smaller dose is required, the desire being to stop haemorrhage with the expectation that normal menstruation may be re-established. Unfortunately all patients do not react to the same degree, and while some continue to show intractable bleeding requiring further treatment, others are so radio-sensitive as to have permanent cessation of ovarian function.

Hysterectomy is to be preferred to irradiation in women under forty-five years, as it allows conservation of ovarian function. It is preferable also if there is any question of a complicating condition. Therefore, if there is a history of pain or if on examination there is tenderness in the pelvis or should the uterus be fixed in retroversion, the seemingly more radical measure may

prove to be the more rational solution to the problem.

Not infrequently the cervix will present signs of chronic infection or erosion, and also many of the patients may require surgical treatment for relaxation of pelvic supporting structures. Under these circumstances obviously hysterectomy is preferable to irradiation.

A study which we have made recently of patients coming to the Cancer Institute with cancer of the cervix after hysterectomy has indicated that too often supra vaginal hysterectomy is performed for uterine bleeding without a careful pre-operative examination to rule out the possibility of cancer. It is also suggested that total hysterectomy is preferable to the incomplete removal of the uterus. The residual cervix is always potentially dangerous, and the fact that supra vaginal hysterectomy is within the scope of one's operating skill while total hysterectomy is not, does not justify the choice of the incomplete operation.

The occurrence of uterine bleeding after the menopause is always of grave significance as it has been repeatedly shown that two-thirds of the women with this symptom have malignant disease. It is probably generally known by now that the wide use of di-ethyl stilboestrol in the treatment of menopausal neurovascular disturbances has been responsible for many cases of bleeding at this time. It is doubtful whether malignant change in the endometrium has ever been caused in this way. Nevertheless, the bleeding will naturally be a cause for concern, and it has necessitated curettage many times to rule out the possibility of malignancy.

One of the most interesting developments in gynaecology has been the study of the functional tumours of the ovary. These tumours continue to produce the normal secretion of the cells which compose them—often in excessive amounts. As a result they are responsible for striking changes in the individuals in which they occur. Brief reference to one of the more frequently occurring tumours of this type is justified because it is typically manifested by the occurrence of irregular uterine bleeding, especially after the menopause. Granulosa cell tumours of the ovary are composed of cells similar to those which are responsible for the secretion of estrin; therefore the bleeding from the uterus which occurs as a feature of this new growth is similar in nature. When bleeding occurs in a woman who has passed the menopause and the curettings show glandular hyperplasia, the possibility of granulosa cell tumour must be considered. If an enlargement of the ovary is palpable, it justifies laparotomy.

Conclusions

1. The treatment of abnormal uterine bleeding in a patient of any age should be based on the firm foundation of a proper diagnosis.
2. Except in the case of very young patients, an examination cannot be considered to be complete without diagnostic curettage.
3. Endocrine therapy does not provide a specific treatment for functional uterine bleeding.
4. Surgery and, in some cases, irradiation

therapy is the best treatment for the vast majority of the conditions which cause abnormal uterine bleeding.

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Everyday Orthopedics

First Paper of a Series, Henry Funk, M.D.

There are many common orthopedic lesions which are called "minor" but which cause so much misery and incapacitation that to the sufferer they are definitely "major" conditions. In this series of articles we mean to consider the nature and treatment of some of these everyday ailments which sometimes are almost as troublesome to the doctor as they are to the patient.

The two most common complaints which lead patients to seek orthopedic advice are foot strain and backache. Both conditions have many causes but the two are so often associated that in every patient complaining of backache the feet should be carefully examined. If trouble is found in the feet and this is corrected the backache will often disappear almost dramatically. In this article we shall consider foot-strain.

Foot Strain

Foot strain may develop quickly or slowly. The acute form is often precipitated by change in occupation. Thus a person ordinarily of sedentary habits may be compelled to do an unaccustomed amount of walking. This strains the feet. If the walking has to be done on hard floors and the footwear is unsuitable, severe strain is very likely to result. In chronic cases the onset is slow the severity gradually increases and incapacitation steadily grows worse.

Of the various types of foot strain "metatarsalgia" is the most common, the most easily diagnosed and, by and large, the most readily treated. As the term implies, there is pain in the region of the metatarsals, and it is usually associated with painful calluses underlying the second, third and fourth metatarsal heads.

Foot strain, as a result of pronation or so-called "Flat Foot", may be a separate entity or may occur in conjunction with metatarsalgia. However, a flat or pronated foot is not necessarily a painful foot and, unless producing symptoms, does not require treatment. Such a foot may become painful when subjected to unaccustomed use and is looked upon with disfavour during enlistment, particularly in the infantry.

The complexity of foot mechanics is ordinarily not appreciated. While not as useful an organ as is the hand, the foot has nevertheless a very similar structure. The intrinsic muscles, ligaments and fasciae are important factors in maintaining proper balance and when these cease to function adequately trouble sets in.

When viewed from the medial side the foot presents a definite longitudinal arch which is maintained primarily by the muscles (tibialis anterior and posterior, and flexor hallucis longus) and secondarily, by the plantar fascia and the interosseous ligaments. The forepart of the foot exhibits a transverse arch. The span which consists of the second, third and fourth metatarsals, rests its medial and lateral extremities on the first and fifth metatarsals respectively. This arch in turn is supported by interosseous muscles and ligaments.

The muscles of a joint or, in the case of the foot, of a complexity of joints, constitute its first line of defence and the ligaments the second line. It is evident that if the muscles play out the strain falls on the ligaments. The ligaments are elastic only to a degree and do not tolerate prolonged stretching. Consequently, they lend support only temporarily and, although sensory nerve fibres exist in ligaments, the overstretching does not account for the entire amount of pain. The periosteum, which is a very sensitive structure gives attachment to the ligaments and when unduly pulled upon becomes painful. With the overstretching of the ligaments the span of the transverse arch becomes depressed, and the second third and fourth metatarsal heads become weight bearing.

A foot that shows evidence of metatarsalgia may also display a condition where the toes are pulled into acute flexion at the interphalangeal joints and hyperextended at the metatarsophalangeal joint. The explanation for this lies in the fact that with the abnormal weight bearing on the central metatarsal heads, the individual tends to elevate the forepart of his foot and in so doing brings the extensors of the toes into play

thus producing deformity. To provide protection for these unnatural weight bearing areas nature builds up calluses. Sometimes this dense callus tissue acts in an opposite way and, in place of providing protection, aggravates the condition. For this reason individuals usually obtain a measure of relief by paring the calluses. These, however, merely recur. Frequently one encounters a hard corn developing in the centre of a callus and this acts almost as a pebble in a shoe. This paring process is what the chiropodist capitalizes upon and the individual returns for paring sessions at varying intervals. Such treatment, however, is not curative, is costly and time consuming and does nothing to overcome the causative factor.

Treatment

A measure which, while etiologically only palliative, nevertheless gives permanent relief, is that of modifying the individual's shoes with a metatarsal bar. The writer admits that such modification is not effective in all patients but it is a very simple device, is usually of great value and is worthy of a trial. Objections will possibly be raised that such a measure is not only useless but may aggravate the existing condition and while such may be the case it is not necessarily the fault of the measure but of its application.

The metatarsal bar, as shown in the accompanying diagram, consists of a leather bar tacked on to the sole of the shoe just posterior to the point of pressure on the metatarsal heads. And while this may seem a very simple measure it is still too complex for the shoemaker to apply at his own discretion and the physician may find the correct position only by trial and error. In a well-worn shoe the exact weight bearing area may not be recognizable and one then may have to resort to trying different sites for application of the bar.

Probably the simplest way of ascertaining the correct site of application is for the individual to obtain a pair of new shoes and wear them for a week or two. This usually demonstrates the weight bearing tread most accurately. At times, however, inspection of a well-worn shoe discloses that the toe of the shoe is turned up and the sole shows a tread mark in the form of an oval traversing the sole transversely. The tread on the sole is noted and a rectangular area marked off just behind it as in the diagram. The width of the bar can vary from half an inch to three-quarters of an inch. It is wedge-shaped to conform to the rise of the shank making the sole of the bar flat in line with the sole and heel. Anteriorly the bar is about one-eighth of an inch thick so that when weight is borne the bar creates

an indentation in the sole just posterior to the metatarsal heads.

It will be readily understood that if the bar is placed unduly forward the pressure on the metatarsal heads will be increased and the pain will be aggravated. And one word of caution—such a bar is not intended for high-heeled or spike-heeled shoes. Such a shoe allows for nothing but walking on the metatarsal heads and a bar will serve no useful purpose. Fortunately, such shoes are mainly for evening wear and are seldom used for ordinary walking.



Exercises are helpful in restoring the normal architecture of the foot and in eliminating abnormal sites of weight-bearing but to be effective they must be patiently and persistently carried out. Here are a few. The patient is instructed not to use his arms when rising from a chair but to rise directly upon his feet. He is told to pick up marbles from the floor with his toes. This exercise is enjoyed by children but seems to some adults to be too puerile. It nevertheless develops the intrinsic muscles and strengthens the arches. A third exercise is to stand on one foot and put on the sock and shoe on the other foot.

Usually after several months of wearing a metatarsal bar the calluses disappear spontaneously. Relief may be instantaneous and the patient may find comfort only in shoes with such bars but there is no contraindication to wearing such shoes indefinitely.

Jaundice in Pregnancy

Case Report by A. M. Goodwin, M.D., and Roberta J. McQueen, M.D.

The following is a report of a case of a pregnant woman presenting some of the features of:

1. Toxemia of pregnancy.
2. Acute yellow atrophy of the liver.

November 1, 1944

Mrs. W. Age, 35. Para., 0. Grav., 2. Last normal menstrual period, August 26, 1944. Expected date, June 2, 1945.

Past History

The patient had been married for ten years, and had never become pregnant. Her husband was considered to be fertile, as many motile spermatozoa were present in the examined specimen. Routine investigation for sterility was undertaken. On March 19, 1943, Rubin test for tubal patency showed that gas passed through at a pressure of 110 millimeters of mercury. The test was repeated on April 14, 1943, and gas passed through at a pressure of 160 millimeters of mercury. On July 12, 1943, her basal metabolic rate was minus 10, and small doses of desiccated thyroid were given. On September 28, 1943, Rubin test was again done, and on this occasion gas passed at a pressure of 200 millimeters of mercury. The patient did not menstruate again following this procedure, and on December 10, 1943, was admitted to hospital for abortion of a 10 weeks pregnancy.

In May of the same year she thought another abortion had occurred, but did not seek medical advice.

No other illnesses of importance had occurred in her lifetime. She was a robust individual who had always enjoyed vigorous outdoor sports.

Present Pregnancy

L.N.M.P., August 26th, 1944. E.D., June 2nd, 1945.

Vomiting was severe in the early months—so severe that she was advised to go to hospital for treatment but refused. Vomiting abated but nausea persisted for some weeks, and she lost 7 lbs. in weight between October 2nd, 1944, and November 6th, 1944. On October 2nd, 1944, the B.M.R. was minus 7%.

Blood: Wasserman reaction, negative. Haemoglobin, 84%; R.B.C., 4.1; leucocytes, 9,300; Rh, negative; no anti-Rh bodies present, by several methods.

Following this time the patient remained fairly well but showed a rather excessive gain in weight. From November 6th, 1944, to April 5th, 1945, the gain was 33 lbs., despite fluid restriction and low salt intake. The haemoglobin had fallen to 65% and iron was administered. The blood pressure and urine remained normal.

April 23, 1945

The patient presented herself to the office with marked general oedema and some vomiting; she weighed 170 lbs., a gain of 5 lbs. in 18 days. The B.P. was 142/98; she had few other symptoms, and the urine contained 0.01% albumen. Specific gravity was 1.025. She was admitted to hospital with a diagnosis of toxæmia of pregnancy. Under treatment the weight was reduced 8 lbs. in one week. Blood pressure returned to normal (130/80), but some vomiting persisted, and termination of pregnancy was advised but refused by the patient. She left the hospital on May 1st, against advice.

May 7, 1945

Her husband brought in a specimen of urine which was of an orange hue due to bilirubin. It contained 1.0% albumen, many hyaline, granular and waxy casts, and leucine and tyrosine crystals. The specific gravity was 1.022. He stated that she had vomited daily since leaving hospital one week previously, but had not reported this. He admitted, when questioned, that her skin did appear to be a bit yellow. She was re-admitted to hospital that day with the following complaints: "Severe vomiting, pain in the back, extreme fatigue and exhaustion." Examination showed the patient to be quite jaundiced (icterus index 50). B.P., 140/80. No oedema. Temperature, 102° F. The patient was in extremis and it was thought she would not live.

The patient was given slowly, by intravenous route, 350 cc. of 25% glucose solution. That same evening she was delivered, by Caesarean section with spinal anaesthesia, of a living baby boy, 5 lbs. 13¼ ozs.

Just prior to operation the bleeding time was 6 min. Clotting time was 7 min., and prothrombin time 17 sec. (35% of normal). A further summary of treatment in the operating room is as follows:

500 cc. 5% glucose intravenously.

250 cc. Blood plasma.

1 gm. Calcium Gluconate intravenously
(10% solution).

2 cc. Vitamine K (Kavitan).

Continuous oxygen through nasal catheter.

Post-operatively the wound oozed blood freely. On May 9th the saturated dressing weighed one pound; but there was no unusual vaginal bleeding. Vitamine K was given daily for four days and blood transfusions with Rh negative blood and also blood plasma and glucose. The total amount of blood given was 1,445 cc., in addition to 250 cc. of blood plasma. Total glucose solution given was as follows: 25%, 350 cc.; 10%, 1,000 cc. 5%, 2,000 cc.

On May 8th, 1 gram of calcium gluconate was again given intravenously. Jaundice persisted. Penicillin was given prophylactically for one week owing to elevation of temperature (420,000 units from May 8th to May 15th). Continuous oxygen was administered and protein in the form of amino-acids (Parenamine, Stearns) by duodenal tube, and then by mouth in 15 cc. doses diluted in fruit or tomato juice three times daily until May 17th.

The patient was extremely ill for four days following delivery, when improvement became evident. On May 24th, she and her baby were discharged from hospital, apparently fully recovered.

The following laboratory data is at hand:

April 23, 1945:

Urine—Specific gravity, 1.025. Alb., 0.02%.

Blood—W.R., neg. Rh, neg. (No anti Rh present.)

May 7, 1945:

Urine—Specific gravity, 1.022. Alb., 1%. Hyaline, granular and waxy casts. Leucine and tyrosine crystals. Urobilinogen present in dilution up to 1 in 30.

Icterus Index—50. Hb, 70%.

May 8, 1945:

Cephalin Flocculation—Test positive.

Icterus Index—50.

Blood Glucose—0.12 gms. per 100 cc.

Plasma Proteins—Albumen, 2.8%; Globulin, 2.3%; Fibrinogen, 0.53%. Total proteins, 5.6%.

May 9, 1945:

Urine—Many hyaline and granular casts, and waxy casts. No leucine and tyrosine crystals. Urobilinogen, 1:80 dilution, slight bile in urine.

Blood Haemoglobin—48%. Cell volume, 20.4% (half of normal). Total proteins, by falling drop method, 5.21%. (Below 5.5% oedema usually develops.)

May 9, 1945:

Blood Plasma CO₂ combining power. 36 vols % (normal, 50-70).

Icterus Index 15.

May 10, 1945:

Haemoglobin 51%. Bleeding time, 3 min. Clotting time, 5 min.

Urine—Urobilinogen 1:30 dilution.

May 11, 1945:

CO₂—Combining power, 62 vols. %.

May 12, 1945:

Urine—Albumen 0.01%, no casts. No leucine or tyrosine crystals. Urobilinogen present, 1:200 dilution.

Placenta—No abnormalities seen except a few pale areas showing fibrosis.

Discussion

This interesting case presents features of two of the complications of pregnancy. In the first place she was classified as at April 23, 1945, as case of pre-eclamptic toxæmia, with generalized oedema, elevated blood pressure, abnormal weight gain and albuminuria, and vomiting; all of which responded to rest with fluid and salt restriction and elimination.

In the second instance an entirely different picture is seen in which jaundice and other signs of severe liver damage are outstanding, and in which the previous signs such as oedema, hypertension and weight gain are absent. Vomiting was much more severe, and extreme fatigue was a major symptom. Her Rh was negative, but the child was Rh positive, and showed no signs of haemolytic disease of the newborn. The jaundice could not be explained on the basis of the Rh mechanism. It is possible that one form of toxæmia had merged into the more violent form with the onset of liver damage, or it may be that the acute yellow atrophy (or a lesser degree of this same process) may have been produced by an agent not associated with pregnancy. In this connection it is interesting to note that at this time a number of cases of acute infectious hepatitis were present in the city of Winnipeg.

It is notable that clinical jaundice was much slower to disappear than did the icterus index. Also it is interesting to observe how uterine contraction and retraction prevented uterine bleeding, while at the same time bleeding from the abdominal wound was profuse.

This patient left hospital apparently recovered, but it is difficult to state how this liver may react to future pregnancies or to stress in some other form. I suggest, however, that owing to the great recuperative powers of liver parenchyma that she may be considered to be fully recovered.

In human beings, hepatitis is due to a number of causes acting together, or one following the other, but the experimental work where all factors can be controlled throws light on the solution. The two great causes are: (1) The toxicopathic due to external or internal causes which act immediately, such as chemical poisons producing toxic necrosis; and (2) the trophopathic, or a lack of protein nutrition; the most specific substance being methionine, an amino acid found in large quantities in milk. No liver damage is seen after protein has been withheld for several weeks, when the experimental animals often die in convulsions similar to eclampsia.

This patient was literally starved for a period of one week from May 1st until her re-admission to hospital on May 7th, by persistent vomiting and by great nausea for food, and by a determina-

tion of her own will to carry on to term, even against advice so that her baby might be saved.

In this connection an illuminating observation was put forward by Dr. Allan Duncan of Dawson City, Yukon Territory. He stated that in the far north the poor man's staple food is cariboo, polar bear and other wild life, almost entirely protein. Very little carbohydrate is eaten by the Eskimo.

Clinical Luncheon Reports

St. Boniface Hospital

Early Post-Operative Rising

Dr. R. O. Burrell

Out of 128 major operations performed between September 1st, 1945, and December 1st, 1945, 36 were allowed to get out of bed early. These cases included 8 appendectomies; 5 pelvic operations; 5 hernia; 3 cholecystectomies; 4 thyroidectomies; 4 gastric operations; 3 lumbar sympathectomies; 1 ureteric calculus; 1 colectomy; 1 thyroglossal cyst. These patients were selected on the basis of suitability of the operative procedure for early rising and proper psychological attitude. With two exceptions, the incisions were transverse, and also with the exception of the hernias, in which silk was used, the wounds were closed with fine interrupted chromic gut. Most of these patients were out of bed within the first 24 hours, and some on the day of operation.

It is difficult to convey, statistically, the extremely favorable impression gained from observing the results in these cases. Their morale is excellent and improves day by day. None were catheterized and many had a natural bowel movement in the bathroom. Patients were allowed to eat what they wished and incidents of gas pains seemed to be much lower. There were no complications of early rising, but one patient did die. She had a right hemi-colectomy for very advanced carcinoma, at the age of 84. Primary anastomosis was done and she developed a progressive gangrene of her wound. This was noticed about the tenth day and she died about forty days post-operatively from uncontrollable spreading gangrene.

The first published report on early rising was in 1899 in the Journal of the American Medical Association. Since that time the surgical literature has contained increasing numbers of very favorable and enthusiastic reports, involving literally thousands of cases. There are apparently no adverse reports in the literature. For the past two years the vogue has become popular in North America.

Early rising does much to prevent post-operative pulmonary complications and thromboembolism. The arguments against early rising are largely theoretical. The incident of wound

Dr. Duncan, who has cared for many hundreds of obstetrical cases among these people, has not seen a case of eclampsia, pre-eclamptic toxæmia or jaundice complicating pregnancy.

Reference

Himsworth and Glynn. *Lancet*, 1944, 1 (Ap. 8), 6293.

separation is no greater. The argument that patients are too miserable to rise early, or that bed rest is valuable, is fallacious. The fear of medico-legal consequences is well founded and will only be lost if early rising becomes popular.

Discussion was lengthy and many interesting points were brought out. In conclusion it was suggested that the operating room keep a record of all cases of early rising in the hospital so that in the course of a year a larger number of cases could be presented for statistical survey.

St. Joseph's Hospital

Acute Appendicitis Associated With Myelogenous Leukaemia

A man of 43 was seen two days after the development of umbilical pain and profuse diarrhoea. He had no nausea or vomiting but felt "weak all over." General examination showed temperature of 99, pulse of 85, blood pressure of 120/80. There were no abnormal findings in the chest. The abdomen was exceedingly tender over the appendix. The liver and spleen appeared to be normal in size. The urine was negative. The white cell count was 69,600. He was sent to hospital where the white cell count was checked and found to be 75,000, 80% polymorphs. The cells were reported as being normal in appearance. It was felt that, whatever the blood picture might indicate, the patient had an acutely inflamed appendix. Accordingly he was operated upon and an acutely inflamed appendix, with pus in its lumen, was removed.

The inquiry then turned to the nature of the blood disturbance. The day after operation the leucocyte count was 96,000, the next day 128,000, two days later 95,000. About a week after operation removal of the dressing revealed widespread ecchymosis. The bleeding time was then found to be 2½ minutes and the clotting time 3 minutes. The haemoglobin was 75%, the platelet count 102,000 and the prothrombin time 40 seconds. The patient was seen by Dr. J. D. Adamson who found the spleen somewhat large and diagnosed the condition as myelogenous leukaemia. A blood count done a few days later showed a red cell count of 4,300,000, haemoglobin 39%, white cells 127,200, polymorphs 65%, myelocytes 23%, and

myeloblasts 2%. The patient was then given X-radiation. Eight days later the leucocyte count was 71,000 with 16% myelocytes. A week later after further radiation the count was 28,900 white cells and two weeks after this 12,900.

Victoria Hospital

Dissecting Aneurysm of the Aorta

Dr. A. M. Campbell

Dr. Campbell reported the case of a man of 61 who took ill at his work with weakness and vague discomfort as his chief symptoms. When seen at home he complained of a "rushing sound" in his chest and weakness. Examination revealed disturbed cardiac rhythm and abnormal sounds which were suggestive of aortic insufficiency. The patient was sent to hospital and was able to sleep but about midnight he was awakened by a very intense pain which persisted for an hour and in which he died.

Dr. Lederman reported the autopsy findings. "There was moderate cyanosis. The pericardial cavity contains about 500 cc. of freshly clotted blood, the result of rupture, into the pericardium, of a dissecting aneurysm of the aorta. The aorta shows a large dissecting aneurysm extending from the aortic ring to the renal vessels. The dissection involves only the posterior third of the aortic wall. The neck vessels have escaped involvement. The coronary mouths are patent. The split in the intima is about an inch in length and is just above the aortic valve. There is moderate atheroma throughout. The heart is enlarged due to left ventricular hypertrophy and marked general dilatation. Conclusion: Myocardial failure due to haemopericardium, the result of ruptured dissecting aneurysm of the aorta."

Dissecting aneurysm is relatively uncommon. Its incidence as given by various authors is from 1 in 200 to 1 in 500 autopsies. First described by Vesalius in 1557, the world literature up to 1933 contained only 317 reported cases of which only six had been correctly diagnosed ante-mortem. Since then 235 cases have been added with correct ante-mortem diagnosis in 62. There are, according to Willius, three reasons why so many wrong diagnoses are made: (1) Infrequency of the condition; (2) absence of a typical syndrome; (3) a lack of clinical suspicion. Men are affected more often than women. The age of incidence is 40-60, with extremes of 14 months and 100 years.

Hypertension of long standing is the chief predisposing cause. Rupture may occur at rest but usually follows effort (straining, stooping, stretching). The stress of pregnancy or of severe coughing or vomiting may be a sufficient exciting cause. In King George II rupture occurred during defecation. (The effused blood bulged out the aortic wall so as to compress the pulmonary artery and produce rupture of the right ventricle.) Dissection is possible only when there is necrosis of the media.

This necrosis affects a variable extent of the middle third of the aorta both circumferentially and longitudinally. Thus it may involve an inch or so, or the whole length of the aorta. The process is most marked just above the aortic valves. The elastic laminae are degenerated. The intima splits transversely and every heart-beat drives the blood further along the aortic wall until more resistant tissue is encountered. Complete splitting may cause the appearance of a double aorta. Atheroma is rarely if ever a cause of massive dissection. Syphilis, when it occurs, is merely coincidental. The luetic process tends to prevent splitting. Trauma alone is never a cause.

The principal complaint is pain which is typically sudden in onset, thoracic in site and "terrific" in severity. Pain may, however, be absent throughout or it may intermit for hours to days before final rupture into the pericardial sac or elsewhere. It is modified by shock and by the speed and degree of dissection. Deformity of the aortic ring may cause incompetence. The signs and symptoms depend upon the extent of the dissection. Hemiplegia and coma may follow involvement of the carotid. Paraplegia will follow involvement of the intercostals and lumbar arteries. Effused blood, halted by intact media, may cause swellings. Fever, if present, is mild and more often temperature is subnormal. Anaemia and leucocytosis result from the bleeding. The electrocardiogram is not typical. This serves to exclude the condition usually suspected—coronary occlusion. In the absence of a typical syndrome accuracy in diagnosis will depend chiefly on clinical suspicion. Death comes to most patients in a few minutes. Some cases survive for hours, a few for days, very few for weeks. Recovery is exceptional.

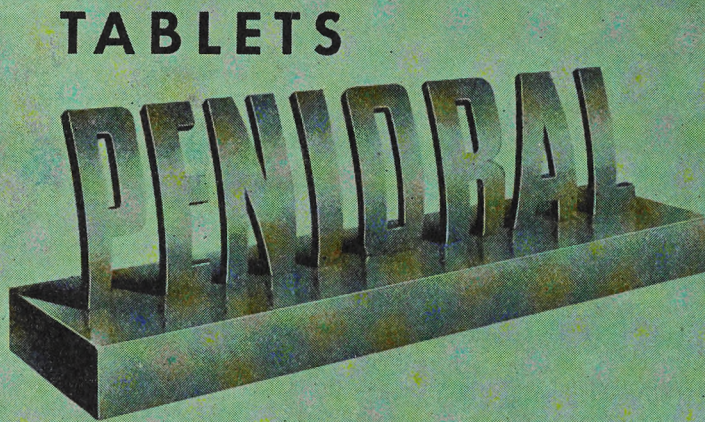
J. C. H.

Septum of Gall-Bladder

Dr. R. Cohen

Dr. Cohen's patient was a man of 33 who had suffered from attacks of abdominal pain and vomiting for over ten years. Eight years ago he had had his appendix removed without relief of his symptoms. About that time an X-ray examination revealed a non-functioning gall-bladder. In May of this year another gall-bladder visualisation was done and reported as showing two large calculi. At operation the gall-bladder appeared to be normal and, on removal, was seen to be so apart from the presence of a septum. Dr. Morrison showed and discussed the films. He said that this was not a very uncommon finding and explained how various accidents of position could result in a picture of an apparently diseased gall-bladder. Dr. Lederman described the pathological processes which could lead to or could follow the development of a septum. Dr. Hogg described the findings at operation. Dr. Cohen said that the patient had been free from all distress since the operation nine months ago.

J. C. H.



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WALKERVILLE, ONTARIO

St. Boniface Hospital

Proceedings of Tumor Clinic at St. Boniface Hospital

Dr. J. W. Simpson

Three cases were presented which were object lessons intended to convey to students and practitioners present, the necessity of making a thorough examination.

The first case was a man aged 48, whose entrance complaint was cough. His illness was of two years duration, during which time he had consulted several physicians, and had a number of chest X-rays, all with negative findings. Dr. Peikoff who last saw him and presented him at the tumor clinic, had put a laryngeal mirror in patient's throat and discovered a marble-sized tumor on epiglottis, which was almost certainly the cause of patient's persistent cough.

Dr. Burrell: "This is a prominent site for cancer. This tumor could be a carcinoma of epiglottis or a dermoid, and a biopsy should be done. Absence of lymph node enlargement tends to rule out malignancy in this case."

Dr. Peikoff: "I think it is a Xanthoma or dermoid. I did not consider malignancy as the tumor seems too smooth. I intend to remove it through the mouth, using intra-tracheal anaesthesia."

After removal, Dr. Prendergast reported that the tumor was a dermoid.

The second case was a man aged 61 years, who had come into hospital a year previously complaining of crampy abdominal pain, and blood in stool, both symptoms being of three months duration. On rectal examination, the interne reported that he could feel a mass at tip of the finger. However, when a barium series and barium enema were reported negative, the man was discharged from hospital.

This patient returned to hospital just a few days ago with the same symptoms as on previous admission, together with increasing constipation and a loss of twenty pounds in weight in the past year.

The barium enema was still negative, but a sigmoidoscopic examination was done and a mass was found about six inches from the anus, a biopsy of which was reported by Dr. Prendergast as grade iii adenocarcinoma.

Dr. Wheeler: "The doctor in charge of the case in 1944 assumed because of negative X-ray report that there was no malignant mass in bowel. It is imperative that we should all recognize that in many cases a barium enema will be negative in lesions of the rectum and lower sigmoid, and when clinical findings and symptoms suggest it, or when in doubt, further examinations, rectal and sigmoidoscopic, should be carried out."

The third case was a woman of thirty-seven years of age, whose entrance complaint was (1) Pain in anal region and diarrhea of five weeks duration and (2) Passage of blood in stool, three weeks previous to admission. Until five weeks previous to admission, she had been in good health. Then she began to develop pain in the anal region when she sat on a hard bench or chair. There was pain at other times. The pain felt as if something were "pushing up" in her anal region, and with its onset, she began to have diarrhea, five or six loose stools daily, but no blood. After two weeks she saw a doctor, who gave her some pills, which relieved her. A few days later she passed some bright red blood in stools and again saw a doctor, who told her she had piles. No rectal examination was made. Later she consulted another physician and following her examination he sent her in to this hospital with a diagnosis of carcinoma of the anal canal.

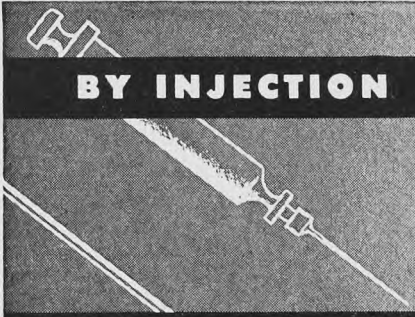
On physical examination, there was a suggestion of a mass in R.L.Q. Rectal examination revealed a hard nodular mass about 1½" long and 1" wide projecting into the lumen from the anterior wall of the rectum just within the ano-cutaneous line. There was a central depression which was painful to touch. It felt like an ulcer with raised, rolled edges which almost met in a vertical line. A biopsy of the tumor was reported as grade ii squamous cell epithelioma, and an abdomino-perineal resection of sigmoid and rectum was done. The posterior wall of the vagina was involved and excised. Lymph nodes were found along the middle haemorrhoidal vessel. The pathological report on specimen was as follows: Anal canal strictured and wall indurated and incorporated in a small lemon-sized extra-anal mass adherent to vaginal wall. Tissue of mass is partly brownish and partly opaque white and cellular looking. Small marble-sized lymph node near bowel wall, above lesion. **Micro:** Histology of melanotic sarcoma. This is a completely different picture when compared with the first biopsy which mimics a squamous cell epithelioma and shows no pigment whatever. The lymph node is involved.

Dr. Wheeler: "This second biopsy shows the histology of melanotic sarcoma. What is the prognosis now?"

Dr. Burrell: "This is rather a rare site for melanotic sarcoma."

Dr. Prendergast: "Prognosis is worse as a result of the delay. Widespread metastasis is very likely to occur."

Dr. Burrell: "The patient is getting radiation now and I would suggest that it also be applied directly into the perineal wound by a small cone inserted there."



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Sixty Years Ago and After

H. M. Speechly, M.R.C.S. (Eng), L.R.C.P. (London), LL.D. (Man.)

When I was 13 years old I badly wanted to go to Dartmouth, the Training School for midshipmen, and become a sailor; but being the son of a poor parson and a missionary in India at that, my naval ambition was crushed, because the parental funds could not stand for it. And so my future remained obscure till in my 18th year, in the spring of 1884, my Father took me away from my beloved school, Monkton Combe, near Bath in Somersetshire, and deprived me of the opportunity of getting into the first xi at cricket! My education had been all on the classical side and my father had a strong leaning towards putting me into Law—was not my barrister uncle Registrar of the City of London Court? The argument was logical from his point of view, but I loathed the idea of a stuffy London office, being very rurally minded. Well, what did I want to be? My choice was "either a doctor or a farmer"; and rather to my surprise my father decided in favour of Medicine. Now one of my father's clergy in India was married to a Miss Treves, who in conversation with my mother had often quite naturally boasted of her brilliant doctor brother at the London Hospital in East London, Mr. Frederick Treves, who was one of the up and coming surgeons on the staff of the biggest hospital in London—the London Hospital on Mile End Road in Whitechapel, one mile east of the Bank of England, and known in medical circles as "The London" with a capacity then of 800 beds. So my father called on Mr. Frederick Treves, F.R.C.S., Eng., to get his advice as to my entering at the London and arranged that I should go to the hospital on a certain date at mid-day to be interviewed and shown over the hospital and medical college by the great man. On the day appointed, as the clock struck twelve, I was duly ushered into the staff room by the hospital porter, Stacey, a short red-whiskered man with gold-laced official frock-coat. And so not a little scared I stood before Mr. Frederick Treves, later as I soon learned, known to all students as "Freddie," much admired and respected. He was a strongly built man of middle height, age 32 only, very young for a senior staff surgeon, keen bespectacled eyes, strong facial profile, and clean shaven except for a dark full moustache. "You are very punctual, young man," quoth he, shook hands, and showed me round the wards. I had reason to believe that my father rather hoped I would be put off by whatever I saw, but neither in the hospital nor in the dissecting room—I had never seen dead bodies before—were my nerves shocked. In the museum, however, the objects that jarred on

my feelings were the bottled anencephalous foetus specimens—they still do!

My mentor took me to see the Warden of the College, a rather formidable-looking bearded expurger in the Navy, Munro Scott by name, who gave me some necessary papers and information. I returned home rather elated at having come through such an ordeal and full of visions of the future. It is rather an odd thing in my life that whether in school or college, in commencing practice in England, or later in Manitoba, I have always encountered and shared in a changing order of things. At school it was in matters of discipline and reorganization; at Medical College—all the big voluntary hospitals in London have their own school—it was exactly the same only more intense, because owing to the influence of Treves and others the whole discipline and structure of the teaching arrangements and of the buildings themselves had just begun to alter in accordance with the impetus given by Lister's teaching and the new conception of bacteriology.

The fall term began on October 1st. Two entrance scholarships were offered, the Science and Arts, but as I had never received any Science training at school, I spent the summer in coaching for the Arts scholarship. The Science scholarships were worth £60 and £40, but the Arts only £40 and £20. W. Soltau Fenwick, afterwards a specialist in Gastrology, won the first Science, and J. H. Sequeira, now a well known dermatologist, got the second; I took the first Arts, and Probyn Williams, later an Anaesthetic specialist, was second. An unfortunate delay, due to some family circumstance, caused me to be late in getting in on the Anatomy class in October, with the result that I, green as grass on such an adventure as anatomical dissection, had to begin on an abdomen, a tough fate for such a one as I! It was puzzling to be told by the Prosector, "Reflect the skin," a new application to me of the verb "to reflect." However, by watching others and heeding a few friendly hints, these strange things became commonplace in due course. Owing to the re-building of the college we had to dissect in a roofless dissecting room without heat and properly cold it was to hands and feet. All students had to dissect for the first two years from October to April. We were under the control of the demonstrator of anatomy, who was already an M.S. and F.R.C.S., under whom two prosectors were in charge of the actual dissectors guiding and advising them, but they were often third and fourth year men who were reading for advanced surgical degrees. Bodies

were not particularly hard to get. The price of your part was 12s. 6d., say three dollars.

The second year test exam. of the Royal College of Surgeons had just been abolished to make way for the regulations of the Conjoint Board of the College of Surgeons and the College of Physicians, two separate bodies except for examination purposes. Each hospital then improved its discipline and arrangements to stop loafing and keep slackers up to the mark. In the basement of our college was a kind of cellar known as "the smoke hole," where you might meet the slacker type, skilled at cards and given to boozy ways, whose entrance to college might be anything from six to ten years previously. This was partly the result of not providing a club room for students. As an alternative there was a "pub" across the street known as "the Good Sam," an abbreviation for the title of the Good Samaritan, the only one of its name in England, I believe. I never entered the precincts of this travesty of true hospitality, though I have had a fair acquaintance with the London pubs. One haunter of Smoke Hole known as "Goblimey Burns," figured unfavourably in a football match on Blackheath. We changed at a certain pub, and as I was wont, I put my watch and purse in my bag in charge of the landlord. A few of the team did the same. Much against our will we had to ask Burns to referee **faute de mieux**. He did — for the first period, and then retired ostensibly for a drink or drinks, but requiring money he cleaned out the pockets of both sides in order to pay for the drinks! My bag happily was in safe hands.

However, with the re-building of the college a better day dawned with the addition of a fine library and the student club-room, so that conditions were vastly more civilized than under the old régime. The day began with a lecture from 9 a.m. for an hour; then followed two hours of dissection, interrupted by an hour for lunch and then another two hours for dissection or longer if there was no afternoon lecture. We had three outstanding lecturers in Frederick Treves on Anatomy, and Jeremiah McCarthy, an Irishman, patriarchally bearded, on Physiology, and the volatile, very theatrical Meymott Tidy on Chemistry. Treves lectured with concise clarity, illustrated by beautiful diagrams on the blackboard, which compelled complete discipline and attention. McCarthy held his hearers to instructed and delighted attention by his witty artistic unfolding of the mysteries of Physiology. Tidy, however, rejoiced in creating a somewhat rollicking audience with a jocularity which often produced gales of laughter without lapse of discipline. How different was the lecturer on Materia Medica, prematurely aged, myopic, and crippled with rheumatoid arthritis. He read monotonously from an

ancient manuscript while all sorts of fun were going on up and down the theatre. A year or two later we had to put up with very dull lectures on Surgery by Rivington and Diseases of Women by Herman, somewhat old stagers with no gift for imparting knowledge.

In 1884 the Volunteer Medical Staff Corps, the first volunteer O.T.C., was organized in London, each hospital forming its own Company of students officered by staff doctors. I joined up at once. We had dark blue uniforms with red pipings, and wore pill-box caps like cavalry; to our white belts were attached short swords with scabbard, but these were only for saluting purposes and had no surgical significance; and when in full dress we wore helmets instead of caps. The idea was to give the men a taste for joining the R.A.M.C. after qualifying and thus to equip them with a knowledge of drill, but I do not remember many men being thus attracted to the Army Medical Service. In addition to drills and forming guards of honour we got regular training. When the Medical College was re-opened in 1886 by the Prince and Princess of Wales I served on the Guard of Honour, and when in 1887 Queen Victoria reviewed 25,000 troops in the Long Valley at Aldershot we stretcher-bearers were 31 hours on duty. In 1887 and 1888 I took the annual week's training at Aldershot given to the V.M.S.C. by the War Office, a very worth-while though too short spell, of which the only hardship was sleeping on the ground with only a rubber sheet intervening.

With regard to sport and cultural clubs amongst students these were isolated units when I joined up, but in 1885 a Student Club Union was consummated after much argument. It was finally decided that the annual subscription should be one guinea per student, but that there should be no compulsion. It was correctly anticipated that practically every student would voluntarily become a member whatever his sporting or intellectual activities and whatever his year. It proved also a mixing agency for juniors with seniors. Of course there was always a distinct line between the first and second years men when you were definitely inferior in status, and the "Housemen," who were superior beings carrying stethoscopes of the bin-aural type which had only recently superseded the old wooden type of Laënnec parentage. Curiously enough during your first winter you had to do six months outpatient surgical dressing. The urologist, Mr. E. Hurry Fenwick, best dressed and handsomest of the Asst. Staff Surgeons, was the surgeon in charge of my group. He was also one of the up-and-coming followers of Listerian principles. I had never done a minor operation in my life, of course. So imagine my acute mental condition when Mr. Fenwick, after describing how

to remove an ingrowing toe-nail, pitched on me to remove the big toe-nail of a girl of about 18 — and with the critical eyes of the rest of the class looking on! Moreover, it was to be done without any local anaesthetic. However, it was done according to instructions, successfully, and the girl never uttered even a groan — she was a heroine! Bacteriology was not taught as a subject, but Mr. Jeremiah McCarthy ("Jerry Mac" to the students), though a Senior Staff Surgeon, actually ran a Primary Pathological class with the use of microscopical specimens! Bio-chemistry was an unknown art. Instruction in Pharmacy was but a flimsy course, especially as most men (myself an exception) had the remains of the old apprenticeship or of family medical connections to reinforce their knowledge of drugs. I have in mind a very pleasant Welshman, Owen Meredith Jones, who had served the old statutory apprenticeship with a medical man in practice which preceded entry into a Medical School up to about 1880. Thus he was a bit older than most of us, had done a lot of dispensing and knew plenty of minor surgery and midwifery. He was chosen H.S. as soon as he qualified, went into the Royal Navy, and happened to be off Chile and Peru when they had their sanguinary scrap at the end of the 19th century. He did a lot of surgery then. When his squadron later went to British Columbia, he resigned his commission to settle in Victoria, B.C., where he enjoyed a large consultant practice until about 1920, when he passed away. I always hoped to see him here in Canada, but never got the chance. Another man who later became a staff physician was Bertie Dawson, who was very scientifically brought up and was in our year; known now all over the British Dominions as Lord Dawson of Penn.

One of my earliest remembrances was the occasion in 1886 when Queen Victoria was to drive past the Hospital to open the People's Palace, a cultural centre. All the students turned out and took the Lodge gates and every point of vantage to cheer Her Majesty when out came the famous Sir Andrew Clark, the senior Staff Physician, who looked after the health of Prime Minister W. E. Gladstone. We gave him a big cheer to acknowledge which he waved his top hat forgetting that it was full of papers! These escaped all over the place — more cheers.

An outstanding figure in those days was the Surgeon Emeritus to the Hospital, Sir Jonathan Hutchinson, whose rural reputation as an animal doctor was almost as great as his knowledge of both medicine and surgery. Like all our older surgeons he grew a spacious beard below his marked expressive features. Bearded also was Dr. Hughlings Jackson (but it was a short white beard) when I was clinical clerk on his service.

He was very shy and modest although he was much respected as a philosophic neurologist. Over and above his description of the unilateral convulsions known as Jacksonian epilepsy he did much to establish the use of the ophthalmoscope in cerebral diagnosis and the doctrine of levels in the nervous system. Unfortunately, he had a peculiar obscurity of speech which prevented him from ever becoming a public lecturer. One had to listen very closely to his clinical remarks to understand him.

Having passed over all Rubicons in your second year you reached the exalted status of "house man" in your third year. For the two years ensuing you took on the functions of clinical clerk on the medical side, and of surgical dresser, six months at least of each, with periods of similar duties in the out-patients. The really interesting time was when a man was on full duty on either medical or surgical sides, but particularly on the surgical. In my day there were five staff surgeons each with his asst. surgeon and house surgeon with six dressers, each of the five units having 70 to 80 beds. On the other side were five staff physicians, each with his asst. physician and house physician with six clinical clerks, each unit having some 60 beds. The period of full duty shared by each unit lasted 3½ days, but surgical full duty was the most exciting. "Full duty" meant that under your peculiar unit all new admissions for the half-week were taken in with certain exceptions. The greater number of admissions was through the Receiving Room (= Casualty).

Until 1885 the king of the Receiving Room was the house surgeon on full duty. In order to relieve the house surgeon and for greater efficiency in avoiding crowding of the Receiving Room the post of Receiving Room Officer was set up for day work only and was regarded as simply an aid to the house surgeon. The Receiving Room Officer, being a recently qualified man, could only admit with the consent of the house surgeon. Soon it became apparent that the appointment achieved only part of its function, and eventually with senior qualified men full responsibility for admissions was given to the Receiving Room Officers, thus enabling the house surgeons to attend to the newly arrived in-patients without disturbance.

To assist the Receiving Room Officer and to give experience, there were always two surgical dressers on duty who attended to all minor complaints and injuries, and learned how to extract teeth. I was one of the few men who took on the Receiving Room Office for the three months' period as soon as I qualified and again later on, after serving as house physician. As each student had to attend at least 20 confinements and most men attended more, the maternity service under

the resident accoucheur was run on a weekly basis by two day men (8 a.m. to 8 p.m.), and two night men who had rooms in the hospital. Business was usually fairly brisk, as there was a huge Jewish population in our area which covered a mile around the hospital. I put in five weeks and bagged 83 cases. We never wore rubber gloves and generally preferred not to wash our hands owing to poor accommodation. Patients were attended by a neighbor, as a rule under most primitive methods, but puerperal fever was unusual. We feared bedbugs more than anything else.

It was optional to attend the Skin Department and only keen men attended. Pathology was a farce, although post-mortem opportunities were abundant: it was common to have from three to six post-mortems most days in the week, but it was only in 1887 that Dr. Percy Kidd completely changed the slack and sloppy ways of his predecessor and really taught pathology scientifically.

Although two large wards, Buxton and Queen Victoria, the one medical and the other surgical, were always full of children up to six years of age, and older children were common in the adult wards, Paediatrics as a subject did not exist; but the wise house physician or house surgeon always took into consideration good hints from Sister Buxton or Sister Queen, who had wide experience of the ever-recurring residents as well as of their small patients. The resident appointments of house physician, house surgeon, and resident accoucheur were made for six months only, but meant grand experience much envied and sought after with relatively limited responsibility. After being Receiving Room Officer and house physician I had the good luck to be house surgeon to Mr. Frederick Treves, then in the height of fame and popularity. The senior staff took ward rounds twice a week from 2 p.m. to 4 p.m., when students and visitors accompanied the surgeon or physician with his house surgeons or physicians and dressers or clerks. Treves always had a tremendous following of from 50 to 70, including many strangers. Operations might take place on any afternoon except Saturday and Sunday, but not in the morning. Emergency operations were covered by the assistant surgeon on duty. It must be remembered that in the 19th century Roentgen's rays were not even dreamed of; rubber gloves were never used; operating was done with bare hands washed in some antiseptic, either carbolic acid solution or perhaps perchloride; and there were none of the present-day meticulous cleansings and swathings of operators and patients. Instruments were not boiled, but were usually dipped in 1 to 20 carbolic solution or some other antiseptic. Only Treves, H. Fenwick and F. S. Eve wore white coats and rubber sleeves. The older men operated in old

frock coats splashed and stained with blood and the various fluid overflows from operations. The Surgery Bedell, as he was called and who had charge of the Operating Theatre, used to tell us that it was only recently that they ceased using the same instruments for post-mortems as for operations, believe it or not! "Did any patients survive operation?" do you ask. Oh, yes, but in that "laudable pus" régime morbidity was much greater than during this century. The only two cases that died during my six months as house surgeon with a prolific operator like Treves were practically moribund at operation, the one being the biggest uterine fibroid I have ever seen, and the other an inguinal hernia of massive proportion extending down to the lower third of the thigh.

Talking of operations, the three commonest items on the day's list were: "Removal of glands from the neck; fistula in ano; and lupus"; and although enlargement of cervical glands were often called "scrofula" and considered "consumptive" in origin, it was by no means certain that the two latter conditions were tubercular. The treatment of lupus by the actual cautery always seemed to me so barbarous, especially when the face of some fair damsel was under that treatment and the theatre was filled with the odour of seared flesh. Later the introduction of what was known as the Finsen Light treatment was adopted, thanks to the generous gift of the late Queen Alexandra. Also when Treves managed to secure for the Elephant Man a haven of rest in Rowsell Ward, she delighted the poor victim of this hideous fibromatosis condition and diabetes by visiting him and giving him her photograph. Remember he was so horribly ugly that he had to have a large cloth mask when he went out at any time, so that he might not scare any feminine observers. We students used to drop in to see him occasionally. I wonder if, when the London Hospital was bombed, the museum which held the mask was destroyed. The Hospital buildings were severely mauled by the 1940 blitz.

Over and above the professional delights of being on full duty when anything might turn up there was one function at midnight which must have mystified waiting patients in the Receiving Room. Nurse after nurse would arrive carrying a bowl with a marked plate on top and deposit it in front of the spacious open fire-place. Before long various residents and dressers would come along, gaze intently on the bowls, and carry off one of them. Each bowl bore a name and contained delicious warm bread and milk! And with this I had better close these reminiscences lest they bore our readers. Nevertheless those were grand and memorable days!



Winnipeg Medical Society—Notice Board

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Next Meeting

January 18th

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Sir Samuel Garth

For some months past the date of our meetings has fallen upon an important anniversary in Medical History. This month again we have such a coincidence, for on January 18th, 1718, there died in London, Sir Samuel Garth.

The name of Garth is not as well remembered as it should be, especially by those who do their daily or weekly stint in some outpatient department for Garth played a very large part in establishing that now universal institution—the Dispensary. There was of course something like it even in the days of the Pharaohs but the modern counterpart was nourished by Garth. Samuel Garth was born in Yorkshire in 1661, studied for a while in Cambridge and then went to Leyden. In 1691 he returned to Cambridge and took his degree or, in other words, “commenced doctor of physic.” The following year he was admitted a Fellow of the College of Physicians and established himself in London. He must have advanced rapidly for in 1697 he was invited to deliver the annual oration in Latin before the College on St. Luke’s Day. His address was notable for two things. First, he spoke warmly about the King. Second, he fulminated against the quackery of the time. William III had been on the throne for only nine years, his wife was dead, he was childless, and the “Old Pretender” had not given up hope of recovering his crown, for he had a considerable body of sympathizers among his former subjects.

Garth’s outright statement put him definitely in the Whig camp and while he had no such thought in mind, it led ultimately to his knighthood. His treatment of the professional topic showed with equal clearness where his sympathies lay in the great quarrel which rent the College. This quarrel was between those whom the law permitted to prescribe (the qualified physicians) and those whom it authorized only to dispense (the apothecaries). The word “apothecary” was first used towards the end of the 11th century in France. In England a body similar in function was incorporated about the same time under the name of the “Guild of Pepperers.” Some of these were herbalists and spice merchants who practiced astrology and various other form of skull-duggery on the side—such as vending poison potions, love charms and the like. Others were little better than grocers taking advantage of this chance of racketeering. By the law of averages the occasional one was probably honest. In 1429

a new charter was given incorporating the “Guild of Grocers” and the apothecaries found themselves included. It is interesting to notice how history is repeating itself in the modern drug-store in which we see reincarnated the medieval “Free-men of the Mystery of Apothecaries and Grocers.”

By the 16th century the apothecaries had advanced from being grocers with a drug department to being assistants to physicians. They found it exceedingly galling to have the local grocer check up on the quality of their wares which by law was his duty. Accordingly during the reign of James I that monarch was asked to give the apothecaries a charter of their own. The grocers protested but the King answered them: “Grocers are but merchants; the business of the apothecary is a mystery; wherefore we think it fitting that they should be a corporation of themselves.” Thus in 1632 we find them formed into “The Apothecaries Company.” They were, however, put under the control of the College of Physicians.

The more ethical confined themselves to dispensing the medicines of the physicians but a good deal of surreptitious counter-prescribing went on as indeed it still does. The less ethical went in for most of their old practices and the whole body got a tremendous boost during the Great Plague. Then almost without exception the whole college (headed by their president) fled the city. When the doctors came back they found the apothecaries so strongly entrenched in public favor as to be most powerful competition, the more so as treatment was completely empirical and the poorly equipped doctor was even more of a menace than the observant apothecary. The two groups were thus brought into open conflict.

In an effort to remedy things the College invoked an Act passed by Henry VIII which forbade apothecaries to prescribe. Cases were unearthed where apothecaries had charged as much as \$30.00 for a single pill, where some had collected as much as \$2,000.00 for the treatment of a single patient, where the drug bill had exceeded \$40.00 a day for a five days’ illness. One such “robber” was hauled into court and got off by saying that he had neither charged nor taken a fee for his advice but only for his medicines. As a result the apothecaries were recognized as being practitioners of a sort.

The next step taken by the College was to pass an edict requiring its Fellows, Candidates and Licentiates to give charitable attention to

their neighborhood poor. This did not work very well, partly because it was as difficult then as it is now to be sure who is a fit object of charity, and because, even if the prescription was free the medicine had still to be bought from the apothecary, and his definition of indigence did not always coincide with that of the prescriber. Besides it is remarkable how quacks can discover hidden sources of wealth even among the very poorest.

The next suggestion was that the College should use its laboratory as a dispensary where the poor could be treated for nothing and their medicines dispensed at cost. This met with a mixed reception. Many of the Fellows reaped a pretty penny from the consultations with which they were favoured by these irregular practitioners. It was probably no different then than it was a little later when Meade sat every morning in one coffee house and every evening in another, not seeing patients but listening to apothecaries relating their symptoms and then prescribing for them at the rate of half a guinea each—a sum, equivalent in our money to \$12.00 or \$15.00. For personal reasons, therefore, the College was divided on the matter of the proposed dispensary and the battle had been going on for some years when Garth in his Oration lauded the Dispensarians and hurled his thunderbolts at the Anti-dispensarians.

The quarrel was taken up in the news-sheets and was the subject of reference by several of the leading literary men of the day, all of whom supported the physicians whose plan, in the words of Johnson: "was on the side of charity against the intrigues of interest, and of regular learning against licentious usurpation of medical authority." Dryden wrote thus:

"Garth, generous as his Muse, prescribes and gives,

The shopman sells and by destruction lives.
Ungrateful tribe! who like the viper's brood,
From Medicine issuing, drink their mother's blood."

But with Garth on their side the Dispensarians scarcely needed the help of lay writers for he belonged to that not inconsiderable fellowship who were doubly the sons of Apollo in that they were not only physicians but also poets. Garth was not a great poet but he was a respectable one. Of his magnum opus, "The Dispensary," Johnson wrote, "No passages fall below mediocrity and few rise above it." In this poem Garth dwells at great length and in vivid style upon the altruism of those who were for, and the vices of those who were against, the dispensary. Garth had taken the metre introduced by Dryden but had so improved upon it that his style was something almost novel. This together with the

importance of his topic and the niceness of his expression made the poem an immediate success. It was published anonymously but the secret of its authorship could not be long kept. It went through many editions and was still widely read twenty years after its appearance.

Shortly after the publication of "The Dispensary" Dryden died in "narrow and neglected circumstances." There seems to be some mystery surrounding the burial of this ornament of English Literature. His friend Lord Halifax undertook to give him a "private gentleman's funeral" and the procession was ready to move off when it was halted by Lord Jeffries, the ribald son of the notorious judge, who appeared at this critical moment with a group of drunken companions. He expressed amazement that nothing better was being done and insisted that he would see that something much more fitting and splendid would be arranged. He then despatched the corpse to an undertaker whom he ordered to embalm it "in the royal manner." He also instructed the Abbey to prepare itself for the reception of this distinguished body. Days went past and the undertaker having received no money and consequently having done no embalming, was anxious to be rid of his guest. He went to Jeffries who told him that it was merely a joke, that he had no interest in the body and did not wish to be bothered with the matter. The now angry undertaker next called upon the widow and threatened to bring the body home and leave it at the door unless something was done. When the story reached the ears of Garth he asked the Censors of the College to give permission for the body to lie in state in their hall and having got it he gathered a subscription to defray the expenses. He himself delivered the funeral oration. A story, which is hard to believe, was circulated to the effect that Garth delivered this oration from the top of a beer barrel and that his platform collapsed during the proceedings. However that may be tickets were issued inviting those interested to attend the ceremonies at the College and Abbey. These were dated the 13th of May and according to Johnson the funeral and interment occurred then and there. But recently evidence has appeared to the effect that burial actually was made eleven days earlier in the churchyard of St. Ann's, Soho. The question is, who lies in which grave?

Garth was the only medical member of the famous Kit-Cat Club. This, the principal Whig club, met at a tavern called the Cat and Fiddle, the host of which was named Christopher, or, more familiarly, Kit. Among its members were the great Marlborough, the famous parliamentarians Godolphin, Halifax and Walpole, the immortal essayists Steel and Addison, as well as

Kneller the artist and many other distinguished men. He was, moreover, on the accession of George I appointed Physician in Ordinary to the King, Physician General of the Army, and was dubbed Knight of the Order of Hanover, on which occasion His Majesty used for the ceremony the jeweled sword of Garth's friend and hero, Marlborough. Garth therefore moved in the highest social and cultural circles but in spite of this he maintained a deep and sincere interest in the needy. To relieve the necessities of the poor was to him far more satisfying than to profit by the advantages of his position. He was, therefore, poor in comparison with many of his professional colleagues. In the words of one of his admirers, "No physician knew his art more or his trade less." In this respect he was the antithesis of Radcliffe whose yearly income sometimes equalled nearly a quarter of a million of our dollars. Radcliffe laid no claims to culture. He read little and wrote nothing yet when he died he left a huge fortune to establish a library. When Garth heard this he said: "For Radcliffe to establish a library is as inappropriate as for a eunuch to found a seraglio." Arbuthnot who was the idol of the Tories as Garth was of the Whigs and who, moreover, like Garth, wrote poetry, was one of his contemporaries. Others were Blackmore, Meade and Sir Hans Sloan. There is extant a note to Sloan reading thus: "Dear Sir Hans, If you can recommend this miserable slut to be fluxed you will do an act of charity for, dear sir, your obedt. servt. Sm. Garth."

In common with many of his calling Garth was not orthodox in the matter of religion. His beliefs, whatever they might have been, he did not parade publicly. On being asked by Addison as to his creed he answered that his was the religion of wise men, and on being pressed to explain what he meant by that he said that wise men kept their own secrets. But as so often happens


what the lips refuse to confess the deeds proclaim, and the deeply religious Pope wrote of him thus: "And Garth, the best good Christian he, although he knows it not."

Some of the finest tributes received by the medical profession were inspired by Garth. Johnson in his *Life of Garth* has this to say about doctors: "Whether what Temple says be true, that physicians have more learning than the other faculties, I will not stay to enquire; but I believe every man has found in physicians great liberality, and dignity of sentiment, very prompt effusion of beneficence, and willingness to exert a lucrative art where there is no hope of lucre." Richard Steele dedicated his play "The Lover" to Garth and in his dedication writes: "And it is as common for Garth to supply the indigent patients with money for food as it is to receive it from the wealthy for physic." Leigh Hunt in his essay on Garth writes of doctors, "We know not indeed who is calculated to excite a liberal enthusiasm if a liberal physician is not. There is not a fine corner in the mind and heart to which he does not appeal; and in relieving the frame, he is often the only means of making virtue comfortable. The physician has been accustomed to the infirmities of his fellow-creatures and therefore understands how much there is in them to be excused as well as relieved."

In May, 1717, Garth's wife died and shortly after he himself began to ail. We are not told the nature of the disease but both Garth and his attendants recognized that it was mortal. There is a story about him loosening the bandage after he had been bled but the bleeding soon stopped, and he decided to let nature take its course. When death did come it came gently even as he himself had written of it:

"To die is landing on some silent shore,
Where billows never beat nor tempests roar.
Ere well we feel the friendly stroke, 'tis o'er."

J. C. H.





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Winnipeg Medical Society—Notice Board

Medical History Section

There will be a meeting of this section on Wednesday, January 23, at 8 p.m., in the Medical Arts Club Rooms. The speaker will be Dr. H. M. Speechly, and his topic: "The History and Lore of Quinine." Now that things are getting back to normal we ought to have a good attendance. These meetings are open to all members of the Society. There are no formalities. Just come, get into a nice comfortable chair, relax and enjoy yourself. For the benefit of those who would like to know something about the early days of this Section we are herewith printing for the first time "The Book of the Chronicles of the Medical History Club."



The Book of the Chronicles of the Medical History Club

Chapter 1.

1. Now it came to pass on the 12th day of the 5th month and in the one thousand nine hundred thirty and first year of our redemption that there came unto me Bill which is called Gardner and he said unto me: Would it be pleasing unto thee to be one of a company which hath for its purpose the study of the history of our craft?

2. And I answered him saying Yea, verily it would please me much to be of such a company. Tell me, I prithee, be there any such?

3. And he answered and said unto me, Alas there be none. Then I said unto him, Be of good cheer for that which is not is that which shall be and speedily.

4. And when I had said this I gat me unto my chamber and pondered upon the matter. Then spake I upon the instrument of two strings unto such as might be of a like mind.

5. And I asked them whether it be yea or nay and they answered me saying Go to. Let it be even as thou hast spoken.

6. And these be they to whom I spake upon the instrument of two strings. There was John surnamed Brodie, he who understandeth the movements of the heart, and John surnamed Gunn who was afore time High Priest in the Temple. And Jaydee son of Adam, the same that is High Priest in many temples.

7. And Ross surnamed Mitchell who bringeth forth the begettings of many men and for whom women cry in the hour of travail. And Fred who remaineth Young even though his years increase.

8. And Bruce surnamed Chown the same that disemboweleth the dead and calleth upon their spirits to rise from the tomb. And we rejoiced that he was of us for we said Peradventure he

will bring unto our meetings the spirits of them of whom we speak.

9. And Harry commonly called Speechly the same that sitteth upon the bodies of them that are dead and who slaughtereth with a mighty slaughter the Children of Culex and the Tribe of Anopheles.

10. And Alvin surnamed Mathers, the same that is now Chief Priest and who understandeth all the mysteries of the soul, yea and of the id and of the ego and of the superego.

11. Unto all these spake I upon the instrument of two strings and they answered me everyone saying: Amen. So be it.

12. And when I had made an end of this matter I returned unto Bill which is called Gardner and spake unto him saying:

13. Behold I bring thee tidings of great joy for that which was not is that which is, namely a Club and the name thereof shall be the Medical History Club.

14. And Bill was astonished and he uttered sounds of joy, yea, he opened his mouth and cried in a loud voice Halleluiah.

15. And I said unto Bill surnamed Gardner, Peradventure it were fitting that the brethren be called together.

15. And Bill answered me saying Thou speakest sooth. Let there be such a coming together and let it be on the even of the day after the morrow. And it was so.

17. And when the day after the morrow had come certain of the brethren did gather together even John surnamed Brodie and Bill surnamed Gardner and I also was among them.

18. Then John surnamed Brodie stood forth in the company and opened his mouth and spake unto us saying, Men and brethren, it is fitting that all things be done decently and in order. Wherefore I beseech ye, as many as are here present, to make a writing which is a constitution whereby we shall all be governed now and for ever more. And we said Amen.

19. Then did John surnamed Brodie bring forth a scroll and showed it unto us and we looked upon it and saw that it was a constitution and we studied it diligently and saw that it was good.

20. And when we had done this Bill which is called Gardner opened his mouth and spake unto us saying Let there be another coming together of the brethren whereat some one of us do speak upon a matter.

21. And we answered him saying Even so and let it be thou that speakest and may the joints of thy tongue be loosened so that thou shalt speak fittingly upon a matter.

22. And Bill answered us saying Let it be even as ye will. And we departed.

Chapter 2.

1. Now when the days were accomplished that Bill should speak unto us there was a great coming together of the brethren.

2. And they came unto the house of Bill and tarried there for a season.

3. And when they were assembled Bill stood forth and spake unto them saying Sirs and brethren, a great thing has come to pass among us, for behold we are a Club, and it is meet that we should do those things that are proper, which is a christening.

4. Therefore I call upon ye all to follow me as I drink of this cup so that our fellowship may prosper. Then brought he forth certain vessels and a bottle of rich and precious wine and he poured it forth for us and bade us drink saying Be ye filled with the spirit.

5. And we partook of the wine and it was of a sweet smelling savour in our nostrils and the taste thereof was as the wine of Scotia and as the honey which filleth the honey combs in the hills of Lebanon.

6. And when we had emptied our vessels the joints of our tongues were loosened and all things were pleasing unto us.

7. Then did Bill surnamed Gardner bring forth a great book and he opened it unto us. And we saw that it was writ in a strange writing and we understood it not.

8. And we said unto him Tell us, oh Bill, we pray thee, what meaneth this? And Bill said unto us: Behold this is the writing of them that dwelt aforetime in the Land of Egypt. And in the tongue of the vulgar, one calleth it the Papyrus of Smith.

9. Now they that wrote it were scribes which were also surgeons and they were cunning men for they knew that there was a time to cut and a time to refrain from cutting and this is to be accounted unto them for wisdom.

10. For even at this hour and among our own kindred there be some who have not that wisdom but who cut whenever the spirit moveth them which is often. Nor will they stay their hand save peradventure he who is sick lacketh the wherewithal.

11. And such be but mere hewers of flesh and drawers of blood. And they be not true surgeons but, as it were, bastards and such have no wisdom.

12. Then spake he much about them that dwelt in the Land of Egypt. And we were astonished that they had such knowledge albeit chirurgery be but the trade of a craftsman.

13. And when we had made an end of speaking upon the matter we hied us unto an inner

chamber and sate us down at a table whereon were rich cakes and we did eat thereof and we did drink of the juice of the grape and of the barley, and a maid-servant brought unto us vessels filled with water wherein had been steeped certain fragrant herbs.

14. And we pledged our fellowship therein and the smell of incense was strong in our nostrils. And after we had tarried about the space of three hours we said Behold this is a goodly fellowship. And we departed.

15. And this is the beginning and the ending of the first session for there were no more meetings in that session.

Chapter 3.

1. Now it came to pass thereafter that there were many meetings, yea from the 9th month even to the 5th month did we meet. And we learned many things that it was fitting that we should know.

2. But of these things I say nothing for verily are they not to be found in the Scroll of the Chronicles of Matters Whereon We Spoke? And there they are to be seen even unto this day.

3. And in those days we came together in the habitation of him who spake.

4. And the fame of our brotherhood was spread abroad so that certain persons came unto us saying, We hear ye have a goodly fellowship whereof I would fain be one. Tell me I pray ye what must a man do to enter this fellowship?

5. And unto these we made answer saying Ye are very welcome and the brethren will rejoice to receive ye into our company. And ye may enter without money and without price so be it ye give your reasonable service which is to come faithfully and speak unto us when ye be asked so to do.

6. And among them that came unto us at that time were Monty who was aforetime High Priest of the Physicians and Harvev surnamed Smith, he who for a season was Chief Ruler of all the physicians in the lands of the Great King.

7. And David surnamed Stewart. And he was a mighty man and he bore upon his shield the cross of two arms, and he fought valiantly against the Captain of the Men of Death and discomfited him sorely so that now he no longer frighteneth us.

8. And we were sore grieved when he was gathered unto his fathers for few there be like unto him. But he hath left his memorial behind him and his name will not be blotted out.

9. And about the same time there came unto us Alec. surnamed Cameron who speaketh not as did his fathers but with the tongue of them that dwell in the city of the Great King. And it is he that gazeth upon the entrails of rabbits and sayeth unto one woman: Be of good cheer

for thou art not so. And unto another Verily that which thou did'st fear has come to pass.

10. And there came unto us also Noel, son of Raw, and he spake unto us upon a matter about the space of three hours.

11. And all these spake unto us upon sundry matters and we received them with joy into our company.

12. And in those days we gathered in the habitation of him who spake and they regaled us ere we departed.

Chapter 4.

1. Now it came to pass that Bill surnamed Gardner was sore at heart for that the fellowship grew not in numbers. And he said unto the company Wherefore are we so few?

2. And the brethren pondered diligently upon the matter for verily our numbers grew not and our hearts were saddened.

3. And Bill surnamed Gardner spake again saying: Peradventure it were better if we came together in the upper story of the House of Physicians. For there could we break bread and others with us and moreover the space thereof is greater than in our habitations.

4. And the brethren saw that this was good and said So be it. And so it came to pass that we came together in the upper story and broke bread at the 7th hour and afterwards we harkened to the discourse of the brethren.

5. And Bill which is called Gardner spake again to the brethren and said Let those among ye who have knowledge of any of a like spirit with ourselves bring them unto our meetings so that our numbers be increased. And the brethren answered him saying Yea we will do so.

6. And there came sundry persons to our meetings. And some came one time or peradventure two times but then no more for our spirit was not in them.

7. And it came to pass that our numbers were still but a few when one of the brethren stood forth in his place and spake unto us saying, Peradventure we should have over us a ruler (for there had been no ruler over us from the beginning).

8. But another of the brethren said: What shall it profit us to have a ruler over us? Let him that speaketh a discourse rule over us for the space of a moon thereafter and so shall we all be ruler in turn. And the brethren said: So be it.

9. And another of the brethren stood forth and said, Have we not a scribe? Let him bear the toil and anguish and upon him let us lay the blame when things go not well? And there was laughter.

10. But I, the scribe, rose in my place and spake unto the assembly saying: My masters,

Verily I am a man of sorrows and acquainted with grief, yet lay not I beseech ye this burden upon my shoulders but let me have two of the company for my councillors and to give me succor. And for their reward let them have the praise when things go not ill.

11. And they questioned me saying: Whom will thou have to aid thee? And I said unto them I will have Bill surnamed Gardner and Ross surnamed Mitchell so be it they are willing. And Bill surnamed Gardner and Ross surnamed Mitchell said, Verily we will go with thee for thy guide in thy most need to be by thy side.

12. And so it came to pass that we three met together and our hearts were heavy within us for that our numbers were few. And we pondered upon the matter.

13. And there came unto me a thought which I held fit for to utter. And I said, What think ye of this? Let us gather together the books which deal with ancient things and which are now in the Room of Books in the Temple and let us set them apart in a chamber and upon the walls of the chamber there shall be drawings and paintings of our fathers in our calling. And let us moreover gather those things that belonged unto them that practiced our craft in this land even from the beginning.

14. And all these things shall be together and in one chamber in the Temple of our craft. And the disciples shall go therein and they shall learn the deeds of their forefathers and meditate thereon. And it shall nourish their souls and make them to strive even as their forefathers did strive against those things which send man unto his long home out of his due season.

15. And let us furthermore keep fresh the memories of them that builded our temple and of them that were priests therein even from the time of its building and before that. For the iniquity of oblivion blindly scattereth its poppy and it is not fitting that those worthy of memorial should be forgotten.

16. And they to whom I spake said, Thy thought is a good one. Go, then, unto the keepers of the Books and say this thing unto them.

17. And it came to pass that I appeared before the keepers of the Books of the Temple and the Chief Keeper was Dan son of Nichol.

18. And I spake unto him and he answered me saying, Verily what thou hast said is very good and peradventure we may do the things that thou desirest. But tell me, hast thou many sheckels?

19. And I said unto him What need be there of sheckels? And he answered me saying There shall be need of shelves whereon to set the writings and thou shalt need also cases wherein

to place the things that thou shalt gather and for these thou shalt need many sheckels.

20. And I was wroth and I said unto him, In our fellowship we speak not of such things but of more noble things, nor forsooth have we any sheckels, nor doth it seem to me needful that there be more than a few small pieces of silver for what we require. And moreover rare and precious books will be given into thy keeping whereby thou wilt be enriched. But he harkened not unto me but only lifted his shoulders and said Come unto us again and we shall speak to thee so be it thou can'st tell us that thou hast the sheckels.

21. And I departed exceedingly sorrowful yet nevertheless I held within me the hope that this thing might yet be.

Chapter 5

1. But there came unto us others in whom was our spirit so that our numbers did increase. And amongst them were Larus son of Sigurd who is of the seed of Thor and Wodin.

2. And Gerard son of Alli and he was faithful in his coming but he took unto himself a wife and now he goeth not forth in the evenings. And Ian son of Thom, the same that maketh the dry bones to live even as it was in the vision of the Prophet Ezekiel.

3. And John surnamed Hillsman who cometh from a far country wherein the people be of many colors. For amongst them be Scarlett and Rhett and many be of the hue of the Ethiopian. And he persisteth in saying Edinburg which is an abomination and an offence in the ears of all the children of Caledonia who know that the name thereof is Edinburra. And fain would we have him desist from the heresy.

4. And also there came David surnamed Swartz, he who cutteth for the stone, and Simon called Jauvoish who is a writer of books and these be of the tribe of Juda. And Digby surnamed Wheeler who peradventure likewise is of the tribe of Juda for verily he gathereth great riches.

5. And all these spake unto us and have abided with us. And they who were of us from the beginning likewise left us not but spake unto us some one time and some twice and some, peradventure, three times. But Bruce surnamed Chown came not for he said My spirits come not where ye are.

6. But John surnamed Gunn whensoever he spoke unto us did bring with him certain choice and ardent spirits which entered into us. So that the brethren would say Tell us we pray thee when shall we hear again John surnamed Gunn, for his discourse is pleasing unto us but not his discourse only but likewise the spirit with which it is given.

7. And John surnamed Gunn left us for a season for like Peter's wife's mother he lay sick of a fever. And the surgeons laid hands upon him so that there might be fulfilled the saying "Whoso sheddeth man's blood by man shall his blood be shed."

Chapter 6.

1. Now it came to pass that the fame of our fellowship was spread abroad so that it came unto the ears of the Chief Ruler of the Society even Fred surnamed McGuinness. And it is he who is a mighty wielder of the tongs and is moreover Chief Guardian of the tentorium. For he sayeth It is given unto many men to repair the perineum but who be there among ye that can mend the tentorium?

2. And Fred said unto me Were it not well that thy fellowship and mine be one? And I considered the matter and said Verily thy saying is true and worthy of all acceptation and I shall tell it unto the brethren. And I did so and the brethren said Verily let us do this thing.

3. And certain of them set their names unto a writing wherein was set forth our desire to become one with the Society. And our writing was read in the Council of the Elders and they blessed it and said So let it be.

4. Then did it become needful for us to have a chief ruler and he who was ruler at the time said unto the brethren Whom will ye have for your ruler?

5. And the brethren cried in a loud voice and as one man We will have Bill surnamed Gardner to be our ruler and may his shadow never grow less and may he live for ever and ever.

6. And when Bill was seated on the high place he spoke unto them saying Brethren we have need also of a scribe and one to speak for us in the Council of the Elders.

7. And the brethren said Let him who hath been our scribe from the beginning be so even now and let him sit in the Council of Elders and speak for us therein.

8. And there was a clapping of hands and it was so.

9. And so it came to pass that the brotherhood became a section of the Society. Wherefore have I written these things that they perish not from our memories.

Chapter 7.

1. And unto them that shall come after us say I this. I pray, yea with all my heart and with all my soul do I pray and the brethren likewise, that ye let not this thing perish at your hands, but cherish it and foster it till it become a great thing among ye, for so shall ye prosper.

2. For it is a sweet and a beautiful thing that ye should come together to praise famous men and the fathers that begat ye.

3. Let not their glory be blotted out but set their light upon an high place where it can be seen of all men and more especially of those youths and maidens that be your disciples, so that they may ponder thereon and sware that they shall bear themselves worthily as becomes such high lineage.

4. And, I beseech ye, let there be among ye neither Jew nor Gentile, Barbarian nor Greek,

but brethren only; for our craft knoweth not a man by his garments or by the temple wherein he prayeth but is one fellowship. Shut not thy door, therefore, against any man that would enter, so be it he is worthy.

5. And may the spirit of Imhotep the Egyptian, and Hippocrates the Greek, and Avicenna the Arab and Maimonides the Jew and all others our fathers be with you. And may this fellowship prosper at your hands and may it endure for ever and ever.

6. Behold, I have finished.

J. C. H.

Something New

Precordial Pain Due to Muscle Strain

Precordial pain may be due to strain of the pectoralis minor muscle. On the left side where angina may be simulated, the site of pain is in the mid-clavicular line and in the region of the third to fifth ribs. The pain is intermittent and may radiate to the shoulder but never invades the arm. It is produced by movement of the arm and can be reproduced by pushing forward against resistance the patient's laterally outstretched arms. This manoeuvre serves to localise the pain and injection of the site with novocaine will cause its disappearance. (Mendelowitz, M., *Am. Heart J.*, 30: 123.)

Vitamineral Therapy in Hyperthyroidism

In hyperthyroidism there is a disturbance of calcium and phosphorus metabolism. Excretion of those minerals is so increased that double the normal intake is necessary to maintain normal balance. The disturbance varies greatly in degree and is reversible and preventable. The calcium demand, which may be as high as 3 grammes daily, can be met by giving some salt such as chloride, gluconate or lactate orally or parenterally. Dicalcium phosphate is especially indicated with vitamin D to assure retention. Adequate

mineral and vitamin therapy controls pain in muscles, bones and joints, prevents complications due to decalcification of the bones, lessens the tendency to post-operative crises and enhances the action of thiouracil and X-ray. In addition the diet should be high in calories and protein. (Puppel, I. D., et al, *Surg. Gynec. & Obst.*, 81:243.)

Sulphonamides when used in the treatment of skin diseases should be restricted to those conditions that resist other treatment and oral administration should not be extended over ten days because of the danger of sensitising the patient. According to Tobias the following diseases are indications for the use of sulphonamides: chancroid, erysipelas, widespread impetigo and pyodermas, streptococcic dermatitis, cellulitis complicating furuncles, acute lymphangitis, erythema nodosum and erythema scarlatiniforme if definite pyogenic foci of infection exist. Chronic skin diseases tend to recur when treatment is stopped. In syphilis barbae and chronic axillary abscesses sulpha plus penicillin is more effective than sulphonamide alone. Sulphonamide ointments should be not more than 5%, should be used only when all other measures have failed, and should not be used in eczematoid dermatitis.—*South. Med. Jour.* 38:467.

Help the Library

There are, both in and out of town, a number of groups of doctors, each member of which gets a copy of the Review. After each doctor has had an opportunity to read his own copy the library of the group need not hold more than one or two copies. Those which remain need not find an unworthy grave in "the circular file" (a nice way of saying wastepaper basket). They can be used for exchange purposes. It would be nice to have a copy of the Review in every medical library in the Empire and in the libraries of all of our Imperial contemporaries. I therefore

suggest that those of you who belong to groups send to the Medical Library in the Medical College those copies of the Review which you do not wish to retain. Our library will exchange them for journals which it does not now receive. This will enable it to increase its value to you without increasing its expenses. Where there are no exchanges concerned we shall have the satisfaction of knowing that our kinsmen in all parts of the Commonwealth are being made aware of our doings. Where there are exchanges you can learn what is being done elsewhere.



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Editorial

J. C. Hossack, M.D., C.M. (Man.), Editor
R. B. Mitchell, B.A., M.D., C.M. (Man.), F.R.C.P. (C), Associate Editor

Happy New Year

I wish you all a Happy New Year. How often in the future, I wonder, will that expression find repetition. Twenty-five times? — perhaps; fifty times? — may be; a hundred times? — almost certainly not. History has a habit of repeating itself with monotonous regularity. There are variations of the theme but the theme remains the same. The World has never at any time lacked madmen who thirsted for its mastery and madmen will continue to be begotten. In every generation some terrible weapon has been devised which seemed, at the time, to make war intolerable; but wars continued to be waged. Now we have what seems to be the ultimate in destruction but probably isn't. A generation hence there will be super atomic bombs and likewise there will be madmen with the Alexander-Napoleon-Hitler complex. Let these two come together for a short time and the World will at last have entered the era of universal peace—no one will be left to fight on either side. The World which began in fire will end in fire. We are not only at the beginning of a new year or of a new age but almost at the end of time. With which pleasant thought I leave you to your meditations wishing you again Happy and Prosperous Years — while they last!

J. C. Hossack.

A Letter from Our President

November 7th, 1945.

Dear Editor:

For some time I have felt that the Executive Meetings of our Association should be open to all members. The business we discuss is very important to every doctor. I believe that the members should know what is going on and not be told just once a year. The living of every one is vitally affected by what we, your Executive, decide. You should attend these meetings in your own interest. I therefore extend through the pages of "The Review" an invitation to each and every member to attend the meetings of the Manitoba Medical Association Executive. However, you will understand that it is impossible to allow the full Membership to take part in any discussions of the Executive, but it is their privilege to listen-in. Then, if they hear anything contentious they can write to the Executive, and will receive a hearing at the next meeting.

Executive Meetings are held on the Third Sunday of each month in the Medical Arts Club Rooms at 1.30 p.m. As the accommodation is limited, it would be appreciated if any members who desire to attend the meeting would notify Miss Brown, the Secretary, two days prior to the meeting, so that accommodation can be arranged.

Yours very truly,

P. H. McNulty, M.D.,
President.

Help Wanted

"V-T" Day will come only when tuberculosis has been completely eradicated, and until that day comes the fight must be waged incessantly. At the moment there is great need for workers in this field. Doctors who are undecided as to their future might do well to get in touch with Dr. Ross.

December 28, 1945.

Dear Doctor Hossack,

The Anti-tuberculosis programme in Manitoba is being definitely handicapped at the present time because of shortage of medical staff. We require at least three more doctors to give necessary service to patients in the Sanatorium Board's institutions, and especially need added help for our Travelling Tuberculosis Clinics and Tuberculosis Surveys, that is, our preventive work which we have intensified and should do so to a much greater extent.

At a recent meeting of our Medical Advisory Committee of our Board, of which Dr. Ross Mitchell is Chairman, the matter of doctors for tuberculosis work was discussed and Dr. Mitchell suggested that the Manitoba Medical Bulletin would be a good medium to reach the medical men of the Province, and I was wondering if you would mind doing this, asking anyone who is interested to communicate with me.

With best wishes for the New Year,

Yours sincerely,
E. L. Ross,
Medical Director.

Dr. Ross Mitchell

Ever since April, 1925, the name of Dr. Ross Mitchell has appeared on every issue of this Journal, either as editor or in some editorial capacity. He has seen it grow from a four-leaf post-card-size bulletin to its present dimensions. More than any other one else he is responsible for that growth. Somehow it does not seem

possible to think of the Review without thinking of Ross Mitchell. You can imagine, then, how sorry we were to learn that Dr. Mitchell has decided to sever this long association. The Executive Committee accepted his resignation with much regret and plan to express in a more tangible manner their appreciation of his long and valuable service.

Medical Practice for Sale

Situated in Suburban Winnipeg. House is a Duplex, top half rented. Ground floor contains fully equipped office, waiting room and living quarters adjoining, all modern conveniences. Full particulars may be had by applying to Box 1000, Manitoba Medical Review, 510 Medical Arts Bldg.

Anaesthetist Society Meeting

The Winnipeg Anaesthetist Society is sponsoring a two-day meeting March 15th and 16th. Dr. Ralph Knight of Minneapolis, Minn., will be the guest speaker and we hope for a large turnout from the Western Provinces. All Manitoba doctors are invited. Further information will follow in next issue.

Obituaries

Dr. James Howard Hastings

Dr. James Howard Hastings died suddenly at his home in Winnipeg on December 9 at the age of 57. Born in Midland, Ontario, he received his early education at Barrie and Midland Collegiate where he took an active interest in athletics, especially hockey. He was a member of the intermediate Ontario Hockey Association champions in 1903, and for two years was the youngest player in Senior O.H.A. Graduating from the Kirksville, Mo., School of Osteopathy, he practised in Calgary, then in 1916 came to Winnipeg. In 1929 he graduated in Medicine from the Faculty of Medicine, University of Manitoba. He was a member of the Medical Council of Canada. His widow, two sons and two daughters survive him. One of the sons, Capt. Donald Hastings, R.C.A.M.C., saw service in Italy, and now practises in Winnipeg.

work in New York he returned to Winnipeg in 1899. He continued to practise and reside in Winnipeg till his death, with the exception of several months of post-graduate study in Europe.

Dr. Hutchinson was a member of the Manitoba University Council and a member of the executive of the Manitoba College of Physicians and Surgeons. In 1941 he was made a life member of the Winnipeg Medical Society.

He was zealous in good works: treasurer of the Winnipeg Relief Society, director and chairman of the Board of the Y.M.C.A., active member of Grace United Church, and a strong advocate of temperance.

He is survived by his widow and son, Dr. Harold Hutchinson of Winnipeg.

Dr. James Nelson Hutchinson

Dr. James Nelson Hutchinson died at his home, 171 Yale Ave., Winnipeg, on December 14 at the age of 86. Born in Leskard, Durham County, Ontario, he taught school and attended Canada Business College in Chatham. Coming to Winnipeg in 1884 he was associated with a firm manufacturing agricultural implements. Several years later he began the study of medicine in Manitoba Medical College where he remained for two years, then completed his course in Toronto and Trinity Universities. For three years he practised at Richmond Hill, Ont.; then, after post-graduate

Dr. Aeneas John MacDonnell

Dr. Aeneas John MacDonnell, who practised in Winnipeg for about twenty-five years, and well known as a clinical teacher, died in Victoria, B.C. on November 23, aged 82.

He received his degree in Arts from Queen's University and in Medicine from McGill, the latter in 1888. Moving to Winnipeg he became a lecturer in pathology in Manitoba Medical College in 1891 and later professor of Surgical Anatomy, the professor of Clinical Medicine and physician to the Winnipeg General Hospital until his removal to Victoria. He was president of the College of Physicians and Surgeons of Manitoba. Nineteen years ago he retired from practice. His widow and one son, John, survive him.

Book Review

Everyday Psychiatry. By John D. Campbell, M.D., Commander, M.C., U.S.N.R., Chief Neuropsychiatrist, U.S. Naval Base Hospital No. 8, etc. 320 pages. J. B. Lippincott Company, Montreal. \$7.50.

Judging by its clarity of expression, its conciseness and its timeliness this book should have a large sale. It is written with a background of general practice, with a knowledge of what the general practitioner must know about psychiatry, and in such a way that this new information is easily and understandingly absorbed. Dr. Campbell appreciates the difficulties that face the physician who, wishing to learn something of this specialty, finds himself lost in a welter of hard-to-read literature. "Realizing that the general physician and specialist cannot spare the time to search through endless psychiatric literature, it has been my endeavor here to present what I consider to be the most valuable of the material. This book seeks to fill the gap between medicine and psychiatry." "As soon as the physician develops a knowledge of the abnormal personality types which can be used at the bedside the quality of clinical medicine will be elevated 25 per cent. It will be a step forward in medicine equal to the discovery of the sulpha drugs."

The 320 pages of text are divided into 13 chapters. In the first the reader is introduced to practical psychiatry and is told about the basic personality characteristics—intelligence, conscience, emotional reactions, psychosexual development—and to the secondary characteristics, sociability and

special modes of adjustment. In subsequent chapters these criteria are applied to the various personality types. The mental defective is essentially lacking in intelligence, the psychopath in conscience, the psychoneurotic has abnormal emotional reactions, the homosexual is defective in psychosexual development, abnormality of conscience marks the schizoid and the cyclothymic is characterized by his peculiar emotional response. Each of these abnormal types is analysed and illustrated by case histories. Theory is introduced to explain the phenomena of behaviour but there are no perplexing arguments nor any over-elaboration of theoretical aspects. For those who wish to read more deeply there are abundant references.

There is a chapter on chronic alcoholism and one on rehabilitation but for the general reader the most important of the last three chapters is the one on Personality Examination. Here guidance is given on how to determine the degree or condition of each of the primary and secondary basic personality characteristics. This is made sufficiently simple and practical for it to become part of every routine examination. Indeed it is the object of the author to make the practice of minor psychiatry an everyday procedure. To use his own words "No method in medicine is practical unless it is used frequently enough to become a part of the thinking of the physician." Dr. Campbell supplies a method sufficiently basic to be readily applied and at the same time furnishes a useful introduction to more advanced reading.

J. C. H.

Microfilm Service

Microfilms of journal articles may be obtained from the Army Medical Library Washington, D.C., U.S.A., for only the cost of the postage, if requested by the individual and free if through the library. The Army Medical Library considers the microfilm a substitute for Inter-Library loans, and prefers to send them instead of the journals. Their weekly publication, "Current List of Medical Literature," is received in the library, and contains a classified list of articles which have been filmed during the week. It is possible, however, to procure a microfilm of any article in the Quarterly Cumulative Index Medicus, though there might be some delay in obtaining material which has not already been filmed.

For further information about this service, enquire at the medical library, telephone number 29 545.

Diet Manual

The Kellogg Co. of Canada have prepared a useful "Diet Manual." It consists of a portfolio upon the flaps of which are set forth the composition of 12 diets—light, soft, liquid, high iron, high vitamin, salt free, allergy, high residue, low residue, acid-ash, alkaline-ash and diabetic. In addition fruits and vegetables are arranged according to their carbohydrate content. In the portfolio is a pad of letter-size sheets upon which all common foods are grouped under headings such as beverage, breads, cereals, dairy products and so on, together with the caloric value of domestic measures of each item. By means of these forms it is possible to prescribe an individual diet easily and quickly. This "Diet Manual" will be supplied free to any doctor who requests it.

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Medical Happenings for January

Tuesday, 1—

Luncheon, Misericordia Hospital, 12:30 p.m.

Wednesday, 2—

Tumor Clinic, Winnipeg General Hospital, 9:00 a.m.

Thursday, 3—

Luncheon, Winnipeg General Hospital, 12:30 p.m.

Wednesday, 9—

Tumor Clinic, Winnipeg General Hospital, 9.00 a.m.

Wednesday, 9—

Meeting, Council, Winnipeg Medical Society, 12:30 p.m.

Thursday, 10—

Ward Rounds, Children's Hospital, 11:00 a.m.

Thursday, 10—

Luncheon, St. Boniface Hospital, 12:30 p.m.

Friday, 11—

Tumor Clinic, St. Boniface Hospital, 10:00 a.m.

Tuesday, 15—

Luncheon, Grace Hospital, 12:30 p.m.

Tuesday, 15—

Luncheon, St. Joseph's Hospital, 12:30 p.m.

Wednesday, 16—

Tumor Clinic, Winnipeg General Hospital, 9:00 a.m.

Thursday, 17—

Ward Rounds, Children's Hospital, 11:00 a.m.

Thursday, 17—

Luncheon, Winnipeg General Hospital, 12:30 p.m.

Friday, 18—

Tumor Clinic, St. Boniface Hospital, 10:00 a.m.

Friday, 18—

Meeting, Winnipeg Medical Society, 8:15 p.m., Medical College.

Wednesday, 23—

Tumor Clinic, Winnipeg General Hospital, 9:00 a.m.

Thursday, 24—

Ward Rounds, Children's Hospital, 11:00 a.m.

Thursday, 24—

Luncheon, St. Boniface Hospital, 12:30 p.m.

Friday, 25—

Tumor Clinic, St. Boniface Hospital, 10:00 a.m.

Friday, 25—

Luncheon, Victoria Hospital, 12:30 p.m.

Doctors Returned to Civilian Practice From Armed Forces

The following doctors have been discharged from the services and are now back in practice. Their office addresses and telephone numbers are given so that you may easily inform their old patients where they may be found:

Name	Address	Telephone No.
Adamson, Dr. Gilbert L.,	Winnipeg Clinic, Winnipeg	97 284
Adamson, Dr. J. D.,	Winnipeg General Hospital	87 681
Anderson, Dr. Julius,	185 Maryland St., Winnipeg	404 065
Barrie, Dr. J. G.,	11 Rosewarne Ave., St. Vital	204 643
Bell, Dr. P. G.,	Deer Lodge Hospital, Winnipeg	62 821
Bissett, Dr. E. D. R.	Pine Falls, Man.	
Bleeks, Dr. Cherry K.,	105 Medical Arts, Bldg., Wpg.	93 273
Boyd, Dr. Wm. J.,	1012 Ingersoll St., Winnipeg	24 427
Brown, Dr. M. M.,	508 Medical Arts Bldg., Winnipeg	93 889
Cadham, Dr. R. G.,	City Hall, Winnipeg	849 122
Carleton, Dr. M.,	603 Boyd Bldg., Winnipeg	94 763
Clark, Dr. C. W.,	216 Medical Arts Bldg., Winnipeg	94 354
Cohen, Dr. R.,	600 Boyd Bldg., Winnipeg	93 275
Coke, Dr. R.,	Royal Alexandra Hotel, Winnipeg	92 141
Cooper, Dr. Ross H.,	212 Medical Arts Bldg., Winnipeg	93 103
Corrigan, Dr. C. E.,	307 Waterloo St., Winnipeg	401 271
Cram, Dr. J. B.,	409 Power Bldg., Winnipeg	95 165
Crawford, Dr. C. S.	The Pas, Man.	
Croll, Dr. L. D.,	661 Broadway, Winnipeg	72 138
Davidson, Dr. Kenneth,	6 Medical Arts Bldg., Wpg.	95 683
Davidson, Dr. A. M.,	6 Medical Arts Bldg., Winnipeg	95 683
Downey, Dr. J. L.,	333 Bartlett Ave., Winnipeg	46 751
Easton, Dr. S.,	216-7 Curry Bldg., Winnipeg	26 477
Elvin, Dr. Norman L.,	314 Medical Arts Bldg., Wpg.	95 317
Fahrni, Dr. Gordon S.,	105 Medical Arts Bldg., Wpg.	93 273
Fairfield, Dr. G. C.	Portage la Prairie, Man.	
Flett, Dr. R. O.,	203 Medical Arts Bldg., Winnipeg	92 934
Hall, Dr. C. W.,	1328 Pembina Highway, Fort Garry, Man.	49 498
Hamilton, Dr. Glen F.,	408 Medical Arts Bldg., Wpg.	93 846
Henneberg, Dr. C. C.,	302 Medical Arts Bldg., Wpg.	92 710
Hillsman, Dr. J. A.,	308 Medical Arts Bldg., Winnipeg	97 329
Hitesman, Dr. R. J.,	512 Medical Arts Bldg., Wpg.	94 808
Jacks, Dr. Q. D.,	1184 Wolseley Ave., Winnipeg	

Jauvoish, Dr. S.,	206 Boyd Bldg., Winnipeg	93 240
Klass, Dr. A. A.,	132 Matheson Ave., Winnipeg	55 022
Kobrinisky, Dr. Sydney,	505 Boyd Bldg., Winnipeg	93 912
Lansdown, Dr. L. P.	Pine Falls, Man.	
Lebbetter, Dr. T. A.,	Winnipeg Clinic, Winnipeg	97 284
Lotimer, Dr. L. E.,	Winnipeg Clinic, Winnipeg	97 284
Lund, Dr. P. C.,	Deer Lodge Hospital, Winnipeg	62 821
Lyons, Dr. R.,	420 Niagara St., Winnipeg	404 009
MacDonnel, Dr. J. A. K. (lady),	Winnipeg Clinic	97 284
MacKinnon, Dr. W. B.,	661 Broadway, Winnipeg	72 138
MacLeod, Dr. J. W.,	Winnipeg Clinic, Winnipeg	97 284
MacNeil, Dr. Robt. W.,	Children's Hospital, Winnipeg	37 271
Malkin, Dr. S.,	701 Boyd Bldg., Winnipeg	97 223
Mathewson, Dr. F. A. L.,	308 Med. Arts Bldg., Wpg.	94 942
McFarlane, Dr. R. H.,	Internes' Quarters, General Hospital, Winnipeg	87 681
McIntyre, Dr. Donald N. C.,	303 Med. Arts Bldg., Wpg.	92 639
McKenty, Dr. J. Stewart,	514 Med. Arts Bldg., Wpg.	92 711
McKenty, Dr. V. J.,	205 Boyd Bldg., Winnipeg	94 112
McLandress, Dr. Murray,	Apt. "D" Brentwood Lodge, Winnipeg	42 490
McNicol, Dr. H. L.,	Deer Lodge Hospital, Winnipeg	62 821
Medovy, Dr. Harry,	401 Boyd Bldg., Winnipeg	93 849
Neilson, Dr. Clive,	404 Medical Arts Bldg., Winnipeg	94 041
Perrin, Dr. M. B.,	614 Medical Arts Bldg., Winnipeg	98 740
Ramsey, Dr. F. G.,	90 Lenore St., Winnipeg	39 531
Revell, Dr. D. G.,	Winnipeg General Hospital, Wpg.	87 681
Richardson, Dr. R. W.,	105 Medical Arts Bldg., Wpg.	93 273
Riley, Dr. H. W.,	Winnipeg Clinic, Winnipeg	97 284
Rosenfield, Dr. V. L.,	405 Avenue Bldg., Winnipeg	97 141
Rumball, Dr. A. C.,	Deer Lodge Hospital, Winnipeg	62 821
Smith, Dr. F. Hartley,	86 Tache Ave., Norwood, Man.	203 993
Sommerville, Dr. A. N.,	614 St. Mary's Rd., St. Vital	
Stephenson, Dr. Earl,	409 Power Bldg., Winnipeg	95 165
Swartz, Dr. David,	303 Medical Arts Bldg., Winnipeg	92 639
Swan, Dr. R. S.,	215 Medical Arts Bldg., Winnipeg	94 354
Tanner, Dr. A. R.,	310 Medical Arts Bldg., Winnipeg	95 946
Tisdale, Dr. Paul K.,	Deer Lodge Hospital, Winnipeg	62 821
Walton, Dr. C. H. A.,	Winnipeg Clinic, Winnipeg	97 284
Walton, Dr. Fred A.,	3 Locarno Apts., Winnipeg	45 719
Whelpley, Dr. E. H.,	586 Ingersoll St., Winnipeg	39 061
Brownlee, Dr. T. I.	Russell, Man.	
Davidson, Dr. D. A.	Cartwright, Man.	
Jacobs, Dr. A. L.	The Pas, Man.	
Varverikos, Dr. E. D.	Selkirk, Man.	

Canada Year Book, 1945

The 1945 edition of the Canada Year Book, published by authorization of the Hon. James A. MacKinnon, M.P., Minister of Trade and Commerce, is announced by the Dominion Bureau of Statistics.

Special Articles

Among the special articles appearing in the present edition are: Physical Geography of the Canadian Eastern Arctic, at pp. 12-19; Canada's Growth in External Status and Canada's Part in the Relief and Rehabilitation of the Occupied Territories, at pp. 74-85; Canadian Oil Production, at pp. 321-325; Changes in Canadian Manufacturing Production from Peace to War, at pp. 364-381; International Air Conferences, at pp. 642-644; The Wartime Role of the Steam Railways in Canada, at pp. 648-651; Canada's Northern Airfields, at pp. 705-712; the Democratic Functioning of the Press, at pp. 744-748; and the Activities of the Wartime Prices and Trade Board

in Controlling Prices, Rents and Supplies, at pp. 895-903.

Other Features

Because of public interest in the articles published in former editions of the Canada Year Book, the policy of reprinting such articles as are of continuing value has been approved, and in future a number of these will be made available each year. Information regarding those that can be obtained will hereafter be indicated in the list appearing at the opening pages of each future edition of the Year Book.

In addition to the Special Articles, the regular chapter material has undergone thorough-going revision to reflect latest developments.

The Canada Year Book (Cloth-Bound Edition) is held for sale by the King's Printer, Ottawa, at \$2.00 a copy.

Remittance should be made by money order, postal note or accepted cheque payable to the Receiver General of Canada.

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* Gold et al., J. Pharmacol. 52:187, 1944.

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Personal Notes and Social News

Dr. and Mrs. P. H. McNulty's son, Lieut. Robert Thomas McNulty, R.C.N.(R), was married at St. John, N.B., on January 7th, to Merita, eldest daughter of Mr. and Mrs. Daniel J. Barrett, of St. John. A reception was held for the couple aboard the bridegroom's ship, H.M.C.S. St. Boniface. After the ceremony the couple left for Winnipeg.

Dr. and Mrs. J. S. Stewart of Newdale, Man., celebrated their fiftieth wedding anniversary on Christmas day.

Dr. and Mrs. Allan McCulloch are receiving congratulations on the birth of a daughter (Clare Eloise) at the Winnipeg General Hospital on December 20th, 1945.

Major Louis Cherniok, R.C.A.M.C., after spending his leave visiting his friends in Winnipeg and other Manitoba points, has returned to his station at Teheran, Persia.

Lieut.-Colonel M. R. Elliott, R.C.A.M.C. overseas, has been awarded the Order of the British Empire for outstanding work while serving with Canadian army headquarters in North-western Europe.

The executive and members of this Association extend to Capt. Donald J. Hastings, their deepest sympathy on the recent loss of his father, Dr. James Howard Hastings, who died December 9th, at the age of 57 years.

Dr. Harvey L. McNichol, formerly of Deer Lodge military hospital, Winnipeg, is now associated with the Flin Flon Clinic.

Dr. A. A. Keenberg, formerly of Glenboro, Man., has returned from New York, where he took a post-graduate course in internal medicine at the New York Polyclinic hospital. He is now practicing at 901 Boyd Building, Winnipeg.

Dr. R. E. Helgason has taken up practice at Glenboro, Man.

Dr. C. B. Schoemperlen, recently demobilized from the R.C.A.M.C., is now associated with the MacCharles Surgical Clinic at 216 Medical Arts Building.

Dr. H. W. Riley is now associated with the Winnipeg Clinic.

Dr. M. C. Gyde has entered medical practice at St. Pierre, Man.

Dr. John A. Kilgour, recently returned from overseas, will enter civilian practice as an associate at the Winnipeg Clinic.

Dr. C. W. Hall, recently demobilized from the R.C.A.F., has now entered civilian practice, with offices at 1328 Pembina Highway.

Dr. G. M. Stephens, recently with the R.C.A.F., has resumed his former position with the City of Winnipeg Health Department.

Dr. David Swartz, recently demobilized from the R.C.A.M.C., has now resumed civilian practice at 303 Medical Arts Building.

The sympathies of the Executive and Members of the Manitoba Medical Association are extended to Dr. Harold Hutchinson on the death of his father, Dr. James Nelson Hutchinson, who died on December 14th, at the age of 86 years.

Dr. Louis Boxer and Mrs. Boxer have sailed for England, where Dr. Boxer will do post-graduate work at Moorfield's Eye hospital in London.

Dr. C. S. Crawford, recently demobilized from the R.C.A.M.C., has now re-entered civilian practice at The Pas, Man.

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1945		1944		TOTALS	
	Nov. 4 to Dec. 1	Oct. 7 to Nov. 3	Nov. 5 to Dec. 4	Oct. 8 to Nov. 4	Jan. 1 to Dec. 1, '45	Jan. 1 to Dec. 4, '44
Anterior Poliomyelitis	---	3	5	7	19	92
Chickenpox	267	184	238	162	2135	2057
Diphtheria	23	15	38	17	261	206
Diphtheria Carriers	1	---	1	2	34	30
Dysentery—Amoebic	---	---	---	---	1	---
Dysentery—Bacillary	---	6	49	1	19	113
Erysipelas	7	1	1	8	48	62
Encephalitis	---	---	---	1	6	11
Influenza	2	6	11	14	153	234
Measles	6	10	103	82	488	5391
Measles—German	2	---	3	3	38	243
Meningococcal Meningitis	1	2	1	2	13	22
Mumps	62	61	27	9	1377	1499
Ophthalmia Neonatorum	---	---	---	---	---	1
Pneumonia—Lobar	3	12	12	13	111	176
Puerperal Fever	---	---	---	---	---	6
Scarlet Fever	47	82	78	85	683	2049
Septic Sore Throat	5	6	1	---	33	24
Smallpox	---	---	---	---	---	---
Tetanus	---	---	---	---	2	2
Trachoma	---	---	---	---	5	---
Tuberculosis	129	78	28	48	719	619
Typhoid Fever	1	2	5	1	41	49
Typhoid Paratyphoid	---	---	---	---	6	---
Typhoid Carriers	---	---	---	---	4	1
Undulant Fever	---	---	---	1	9	7
Whooping Cough	20	28	29	53	295	423
Gonorrhoea	228	229	161	152	2124	1629
Syphilis	55	45	56	54	655	620
Diarrhoea and Enteritis, under 1 yr.	---	6	---	---	16	---
Actinomycosis	---	---	---	---	---	---

DEATHS FROM COMMUNICABLE DISEASE

October, 1945

DISEASES (White Cases Only)	*725,000 Manitoba	*3,825,000 Ontario	*906,000 Saskatchewan	*2,972,000 Minnesota	*641,000 North Dakota
Actinomycosis	---	---	---	---	---
Anterior Poliomyelitis	---	6	1	23	---
Chickenpox	267	1,313	226	---	34
Diphtheria	22	46	8	43	16
Diphtheria Carriers	1	---	1	---	---
Dysentery—Amoebic	---	1	---	5	---
Dysentery—Bacillary	---	---	---	1	---
Encephalitis, Epidemica	---	---	---	---	1
Erysipelas	7	3	2	---	---
Influenza	2	82	---	3	707
Jaundice—Infectious	---	8	---	---	---
Measles	6	2,041	61	24	10
Measles—German	20	54	8	---	---
Meningococcal Meningitis	1	4	4	10	1
Mumps	62	370	22	---	---
Ophthalmia Neonatorum	---	---	---	---	---
Pneumonia—Lobar	3	---	---	---	---
Scarlet Fever	47	343	22	178	26
Septic Sore Throat	5	3	---	---	---
Smallpox	---	---	---	---	---
Tetanus	---	---	---	---	---
Trachoma	---	---	1	---	1
Tuberculosis	77	199	4	4	24
Typhoid Fever	---	4	---	1	1
Typhoid Carriers	---	---	---	---	---
Typhoid Para-Typhoid	---	2	---	---	---
Undulant Fever	---	8	---	15	3
Whooping Cough	20	194	10	41	26
Gonorrhoea	228	681	---	---	55
Syphilis	55	477	---	---	22

*Approximate population.

Urban—Cancer, 52; Diphtheria, 1; Lethargic Encephalitis, 1; Pneumonia Lobar, 2; Pneumonia (other forms), 6; Syphilis, 6; Tuberculosis, 4; Typhoid Fever, 1; Diarrhoea and Enteritis, 5; Septicemia, 2; Dysentery, 1; Disease of Pharynx and Tonsils, 1. Other deaths under 1 year, 19. Other deaths over 1 year, 222. Stillbirths, 21. Total, 262.

Rural—Cancer, 34; Diphtheria, 2; Influenza, 2; Measles, 1; Pneumonia Lobar, 3; Pneumonia (other forms), 6; Scarlet Fever, 1; Tuberculosis, 17; Whooping Cough, 1; Diarrhoea and Enteritis, 1; Dysentery, 1; Hodgkin's Disease, 2. Other deaths under 1 year, 25. Other deaths over 1 year, 193. Stillbirths, 17. Total, 235.

Indians—Cancer, 1; Influenza, 1; Pneumonia Lobar, 1; Pneumonia (other forms), 5; Tuberculosis, 8; Diarrhoea and Enteritis, 2. Other Deaths under 1 year, 6. Other deaths over 1 year, 5. Stillbirths, 0. Total, 11.

◆
Diphtheria is not showing any decrease in incidence.

Erysipelas shows a slight increase at this time.

Syphilis and **Gonorrhoea** are not decreasing.

Poliomyelitis and **Encephalitis** have both been low in incidence during 1945. Let us hope 1946 will be equally low.

Speaking of 1946, one good resolution for all physicians would be "Resolved, that in 1946 and all succeeding years, I will do everything within my power to immunize and re-immunize all non-immunes against all those communicable diseases for which we have a specific immunizing agent."

The Department of Health and Public Welfare wishes you a happy, prosperous and peaceful New Year.

LESS DIETARY RESTRICTIONS in Peptic Ulcer Therapy

Clinical reports show many patients materially increasing their diets much earlier than heretofore. Gradual increase, under supervision, approaching normal diet, presents no untoward effects. Patients remain asymptomatic. Earlier resumption to normal diet may be an important factor in the unusually rapid recovery sometimes evidenced in Ulcap Therapy.

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Manitoba Medical Service

A doctor sometimes requests authority for an operation when sending in the green report, and is not unreasonably annoyed when it is apparently overlooked. If I tell you what happens, then your co-operation will help to eliminate this difficulty; this is very necessary now when, with better organization, we are scrutinizing reports as to undeclared but pre-existing ailments receiving or requiring attention.

In the first few days of the month as many as two thousand or more reports come in. Each one is stamped with the date received; in due course they are passed to me for checking, assessing, and coding. In an uninterrupted day's work I can cover about 150 cases; fewer, if there is extra information to be obtained. Therefore it may be several days before I reach your request. If you will identify a report containing such a request in some way that will catch our attention or send it in a separate envelope marked "urgent," I can promise you that it will be attended to at once. Sometimes I am called in the evening, but seeing that I have no access to files showing the date of membership, etc., I am unable to give an undertaking that Manitoba Medical Service will accept responsibility for payment.

Please do not make a habit of using the term "adult" in giving the age; even the approximate age is useful in coding, where no information has been given as to whether the disease is functional, degenerative, infectious or congenital; in many cases these have not been identified by the doctor, but knowing the age I can make an estimate without referring back for further information.

Dr. Grant, representative of the Rockefeller Foundation, who was in the city, spent a large part of a forenoon, investigating our set-up, and expressed himself as very much interested in the work being done. The majority of the plans in the United States of America are for surgical and emergency services to a bed patient in hospital. Such plans give little assistance in estimating the requirements of a complete federal, state or provincial health service. Manitoba Medical Service is likely to be of considerable value in this respect.

E. S. Moorhead,
Medical Director.

Administration Notes

Numerous enquiries are received to ascertain who are on our Board of Trustees which I list below:

List of Trustees	Term Expires
Dr. M. R. MacCharles, Chairman	1947
Mr. R. McKay, Vice-Chairman	1947

Dr. H. Cameron, Secretary	1946
Dr. A. C. Abbott, Treasurer	1946
Dr. W. G. Beaton	1948
Dr. G. S. Chown	1946
Dr. B. Dyma	1948
Dr. A. M. Goodwin	1948
Dr. M. D. Grant	1946
Dr. A. Hollenberg	1947
Mr. R. Holmes	1948
Mr. E. Jones	1948
Dr. H. D. Kitchen	1947
Dr. M. Matheson	1946
Dr. R. Mitchell	1947
Dr. F. G. McGuinness	1947
Dr. P. H. McNulty	1946
Mr. J. B. Richardson	1947
Mr. F. W. Ross	1946
Dr. C. B. Stewart	1948
Mr. C. E. Wood	1948

Medical membership as at November 30th, 1945, was 23,509, an increase of 1,021 over October, 1945, which in error was reported to be 24,488 and was 22,488, Plan B still being the more popular.

Accounts were passed for November, 1945, to the amount of \$27,262.75, and paid on the basis of 68.2% or \$18,587.29. There were approximately 3,400 claims received during the month.

Nine doctors have joined our service lately; may be assure them of every assistance in our work; we hope to have their co-operation.

Some 325 to 350 claims per month are now being investigated for pre-existing undeclared ailments and motive in joining. Accounts returned for legitimate reasons have risen from \$601.00 in July, 1945, to \$1,762.00 in November, 1945.

The mornings' mail is quite interesting; often envelopes are not sealed and empty, and there are still numerous claims being received with no signatures, code numbers, group and contract numbers, etc. However, we endeavour to correct these omissions without further demands on your staff.

A. G. Richardson,

Office Manager.

For Brandon General Hospital

Application for position as Radiologist. Applicant applying please give full particulars, regarding experience and salary expected. Apply

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**Chairman of Management Committee
Brandon General Hospital, Brandon, Man.**

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